ECORD
AND
BRIEFS

DEC 19 2016

No. 16-149

IN THE
Supreme Court of the United States

COVENTRY HEALTH CARE OF MISSOURI, INC.,

Petitioner,

v.

JODIE NEVILS,

Respondent.

On Writ Of Certiorari
To The Supreme Court Of Missouri

BRIEF FOR PETITIONER

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QUESTIONS PRESENTED

The Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, governs the health benefits of millions of federal workers and dependents, and authorizes the Office of Personnel Management ("OPM") to enter into contracts with private insurance carriers to administer benefit plans. FEHBA expressly "preempt[s] any State or local law" that would prevent enforcement of "[t]he terms of any contract" between OPM and a carrier which "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1). In a 2015 regulation, OPM codified its longstanding position that FEHBA-contract provisions requiring carriers to seek subrogation or reimbursement "relate to ... benefits" and "payments with respect to benefits," and therefore FEHBA preempts state laws that purport to prevent FEHBA insurance carriers from pursuing subrogation and reimbursement recoveries. 5 C.F.R. § 890.106(h). Expressly disagreeing with multiple federal circuits and state appellate courts, the Missouri Supreme Court nevertheless construed FEHBA not to preempt such state laws—explicitly refusing to accord any deference to OPM's regulation. A majority of the court further concluded that Section 8902(m)(1) violates the Supremacy Clause of the U.S. Constitution. The questions presented are:

1. Whether FEHBA preempts state laws that prevent carriers from seeking subrogation or reimbursement pursuant to their FEHBA contracts.

2. Whether FEHBA's express-preemption provision, 5 U.S.C. § 8902(m)(1), violates the Supremacy Clause.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption.

Xerox Recovery Services, Inc. (formerly known as ACS Recovery Services, Inc.) intervened as an additional defendant in the case, but Xerox and Nevils subsequently settled the claims as between themselves. Xerox is no longer a party to this litigation.

Pursuant to this Court's Rule 29.6, petitioner Coventry Health Care of Missouri, Inc. (formerly Group Health Plan, Inc.) states that it is a wholly owned subsidiary of Aetna Health Holdings, LLC (successor by merger to Coventry Health Care, Inc.). Aetna Health Holdings, LLC, in turn, is a wholly owned subsidiary of Aetna Inc. Aetna Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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BRIEF FOR PETITIONER

Petitioner Coventry Health Care of Missouri, Inc. (formerly Group Health Plan, Inc.) respectfully submits that the judgment of the Supreme Court of Missouri should be reversed.

OPINIONS BELOW

The Missouri Supreme Court's opinion under review (Pet. App. 1a-14a) is reported at 492 S.W.3d 918. That court's prior opinion (Pet. App. 44a-72a) is reported at 418 S.W.3d 451. The Missouri Court of Appeals' opinion (Pet. App. 33a-43a) is not reported but is available at 2012 WL 6689542. The Missouri Circuit Court's decision (Pet. App. 28a-32a) is not reported. The U.S. District Court for the Eastern District of Missouri's ruling remanding to state court (*id.* at 15a-27a) is not reported but is available at 2011 WL 8144366.

JURISDICTION

The Missouri Supreme Court entered judgment on May 3, 2016, accompanied by opinions adjudicating the federal questions presented here. This Court has jurisdiction under 28 U.S.C. § 1257(a). *See Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 476-87 (1975).

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

Section 8902(m)(1) of Title 5, United States Code, provides:

> **§ 8902. Contracting authority**
>
> * * *
>
> (m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.
>
> * * *

Section 8913(a) of Title 5, United States Code, provides:

> **§ 8913. Regulations**
>
> (a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.
>
> * * *

Other pertinent constitutional, statutory, and regulatory provisions are reproduced in the Appendix at 1a.

INTRODUCTION

The health-insurance benefits the federal government provides to federal employees are a fundamentally federal concern. Congress explicitly determined that the administration of those benefits for the workforce of the *Nation's* government requires uniform, *national* rules. In the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, Congress empowered the Office of Personnel Management ("OPM") to establish—in contracts with private insurance carriers—the terms and conditions on which those benefits are provided to millions of federal workers and their families. And to prevent a patchwork of state laws from interfering with OPM's centralized oversight of FEHBA plans and frustrating plans' efficient operation, Congress expressly preempted state laws that purport to trump "[t]he terms of any contract" under FEHBA "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Id.* § 8902(m)(1).

FEHBA's expansive express-preemption provision unambiguously supersedes state laws that nullify FEHBA contracts' reimbursement and subrogation provisions—which require carriers to recoup benefits they have paid to participants who also recover for the same costs from other sources. That follows inexorably from Section 8902(m)(1)'s text. Subrogation and reimbursement "relate to" the "extent" and "provision" of "coverage" and "benefits," and at a minimum to "payments with respect to benefits." State laws restricting such recoveries fall squarely within Section 8902(m)(1) and are preempted.

Congress's purposes powerfully reinforce that plain-text interpretation. Congress enacted (and later broadened) Section 8902(m)(1) to prevent divergent state-law requirements from creating disuniformity, cost inefficiency, and unfairness to participants in the same plan living in different States. Preempting state laws that restrict subrogation and reimbursement recoveries directly "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts," and "translate[s] to premium cost savings for the federal government" (ultimately, taxpayers) and "FEHB enrollees." OPM, *Final Rule, Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 29,203, 29,203 (May 21, 2015) ("*Final Rule*") (Pet. App. 158a).

OPM has long maintained this sensible, straightforward reading of FEHBA, which uniformly prevailed for decades. Lower-court confusion in recent years, however, led OPM to put any uncertainty to rest. In 2015, exercising its express statutory rulemaking authority, 5 U.S.C. § 8913(a), OPM adopted a notice-and-comment regulation codifying its "longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978," as preempting state antisubrogation and antireimbursement laws. *Final Rule*, 80 Fed. Reg. at 29,204-05 (Pet. App. 162a, 165a); 5 C.F.R. § 890.106. That regulation and the deference due under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), eliminate any possible doubt that FEHBA preempts such laws.

The Missouri Supreme Court nevertheless twice held in this case—both before and after OPM's regulation—that FEHBA does *not* preempt state laws, including Missouri's common-law doctrine, restricting subrogation and reimbursement by FEHBA carriers. But none of the grounds it asserted for refusing to apply FEHBA's preemption clause to such laws can be reconciled with the statute or this Court's teaching. Although the court purported to interpret Section 8902(m)(1)'s text, it addressed only selected words—which it construed implausibly—and disregarded other parts of the text altogether. And it never confronted Congress's purposes at all.

The decision below compounded its error by refusing to accord *any* weight to OPM's interpretation. The court did not question the reasonableness of OPM's reading; it held that *Chevron* deference does not apply *at all* because OPM's regulation concerns preemption. The court believed that a presumption against preemption applies instead, and that it compels a miserly construction of FEHBA's preemptive reach. That holding has things exactly backwards. This Court's decisions firmly establish that *Chevron* applies with full force to an agency's interpretation of the scope of a statute that clearly preempts *some* state laws. And the anti-preemption presumption the Missouri Supreme Court substituted for *Chevron* has no application to *express*-preemption clauses—least of all one like Section 8902(m)(1) concerning the *federal* government's provision of benefits for *federal* workers under contracts with a *federal* agency.

The Missouri Supreme Court's artificially narrow construction of FEHBA—if left to stand—will undermine the efficient and fair administration of FEHBA plans. That holding may potentially subject

carriers to class-action liability, even punitive damages, merely for fulfilling their contractual duties to the federal government. Yet the errors and harmful consequences of the court's misreading of the statute pale in comparison to its further holding that FEHBA's preemption provision is *unconstitutional*, and thus presumably preempts nothing. A supermajority of the court concluded, in a concurrence that is also binding precedent in Missouri state courts, that Section 8902(m)(1) violates the Supremacy Clause by purportedly elevating contracts over state laws. That holding rests on a distortion of the statute. Properly construed, FEHBA fully comports with the Clause: It is Section 8902(m)(1) itself that preempts state laws, which is all the Constitution requires.

At a minimum, FEHBA can reasonably be interpreted in that way, and thus must be so construed to avoid any putative constitutional doubt. The Missouri Supreme Court contravened the constitutional-avoidance canon by *creating*, rather than avoiding, a massive constitutional infirmity that the statutory text does not compel. The court's misguided rationale, moreover, would cast grave doubt on other important statutes containing similar preemption provisions—from the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, to the Federal Arbitration Act, 9 U.S.C. § 2.

This Court should reverse the Missouri Supreme Court's erroneous judgment and reaffirm the fundamental principles of federal law that the state court jettisoned. The Court should hold that FEHBA—in light of its plain text, Congress's purposes, and OPM's longstanding, reasonable interpretation—validly supersedes state-law restrictions on subrogation and reimbursement terms of FEHBA contracts.

STATEMENT

1. Congress enacted FEHBA in 1959, creating the Federal Employees Health Benefits Program (the "Program") to provide health-insurance benefits for federal workers. Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708. Congress sought to "assure maximum health benefits for [federal] employees at the lowest possible cost to themselves and to the Government." H.R. Rep. No. 86-957, at 4 (1959) (J.A.272-73). It authorized a federal agency—the Civil Service Commission, later replaced by OPM—to administer the Program, including by "prescrib[ing] regulations necessary to carry out" the statute, 5 U.S.C. § 8913(a), and by entering into contracts with private insurance carriers that administer FEHBA plans, *id.* § 8902(a), in which the agency specifies the "limitations, exclusions, and other definitions of benefits as [it] considers necessary or desirable," *id.* § 8902(d).

Today, the FEHBA Program is "the largest employer-sponsored health benefits program in the United States." Press Release, OPM, *Open Season for Federal Health Benefits, Dental and Vision Insurance, and Flexible Spending Accounts* (Sept. 28, 2016), http://tinyurl.com/jcebm2n. The Program covers "[a]pproximately 85 percent of all Federal employees," *ibid.*—more than 8 million federal workers and dependents—and pays out tens of billions of dollars in benefits annually. *Final Rule,* 80 Fed. Reg. at 29,203 (Pet. App. 160a). The federal government (ultimately, the public) pays the lion's share of premiums (typically 72%)—more than $30 billion each year—and participants pay the remainder. *Ibid.*; 5 U.S.C. § 8906(b)(1). Premiums are deposited into a special U.S. Treasury fund (the "Fund"). *Id.*

§ 8909(a). "[C]ommunity-rated" carriers, which set premiums based on demographics or other attributes of a pool of participants, receive premiums from the Fund up front, from which they pay benefits. 48 C.F.R. §§ 1602.170-2, 1632.170. "Experience-rate[d]" plans, which set premiums based on "actual paid claims" and other costs, draw on the Fund to pay benefits case-by-case. *Id.* § 1602.170-7.

2. In the 1970s, Congress became concerned about state regulation of FEHBA plans, which had "[i]ncreased premium costs to both the Government and enrollees" and created "[a] lack of uniformity of benefits" even "for enrollees in the same plan." H.R. Rep. No. 94-1211, at 3 (1976) (J.A.338). "[E]nrollees in some States" had to pay "a premium based, in part, on the cost of benefits provided only to enrollees in other States." *Ibid.*

Congress sought the views of the Civil Service Commission, which "strongly urge[d]" Congress to adopt an express-preemption provision. H.R. Rep. No. 95-282, at 3 (1977) (J.A.355). As it explained, FEHBA already "preempt[ed] state laws in this area," despite the lack of an express-preemption provision. *Ibid.* (J.A.354). But without an express statutory directive, "enforcement of this preemption policy w[ould] almost inevitably lead to time consuming and costly litigation with the states until [the Commission's] position is finally upheld by the courts," which is neither "necessary" nor "desirable." *Ibid.*; *id.* at 7 (J.A.361-62); S. Rep. No. 95-903, at 3-4, 8 (1978) (J.A. 369, 377).

The Commission also was concerned that—although it understood FEHBA itself as preempting state laws, and FEHBA authorized the Commission to issue regulations to "carry out" the statute,

5 U.S.C. § 8913(a) (1970)—the statute did not afford the agency sufficiently "clear authority to issue regulations" addressing the scope of preemption specifically. S. Rep. No. 95-903, at 4 (J.A.370). The Commission's legal counsel expressed similar views in correspondence with carriers—summarized in a 1975 Comptroller General report to Congress that likewise recommended legislation clarifying the limits of state law. *See* Comptroller General of the United States, Gen. Accounting Office, Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers 15-17 (1975) (J.A.565-67).

Congress adopted the Commission's suggestion, seeking to "clear up the doubt and confusion" and "to clarify the Federal Government's and the Civil Service Commission's authority to regulate implementation of the law." S. Rep. No. 95-903, at 4 (J.A.369-70). In 1978, Congress amended FEHBA by adding an express-preemption provision, *see* Act of Sept. 17, 1978, Pub. L. No. 95-368, 92 Stat. 606, which provided:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

5 U.S.C. § 8902(m)(1) (1982).

After decades of additional experience, Congress concluded that this express-preemption provision did

not go far enough. Congress accordingly amended Section 8902(m)(1) in 1998 to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (1997) (J.A.403). The 1998 amendments broadened Section 8902(m)(1) in two respects. First, they expanded the range of FEHBA contract terms that state laws may not supersede, to include not just terms that "relate to the *nature* or *extent* of coverage or benefits" or benefit payments, but also terms that relate to the "*provision*" of those things. Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (emphases added). Second, Congress deleted the proviso limiting preemption to state laws "inconsistent" with FEHBA contracts. *Ibid.*; *see also* H.R. Rep. No. 105-374, at 16 (J.A.416-17); S. Rep. No. 105-257, at 9, 14-15 (1998) (J.A.456, 468). As amended, Section 8902(m)(1) now provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).

3. The same year Congress enacted FEHBA's original preemption provision, it created OPM, which replaced the now-defunct Commission in administering FEHBA. Civil Service Reform Act of 1978, Pub. L. No. 95-454, §§ 201, 906(a)(2), 92 Stat. 1111, 1118-19, 1224. OPM has overseen the Program ever since.

OPM has long included in its FEHBA contracts provisions requiring carriers to seek subrogation and reimbursement. *E.g.*, Standard Contract for Community-Rated Health Maintenance Organization Carriers § 2.5 (2000) ("2000 Standard Contract"), http://tinyurl.com/joeb6dc. Such provisions apply where a beneficiary receives benefits under her FEHBA plan, but also recovers—or has a right to recover—for the same costs from a third party. If the beneficiary has already recovered from the third party, the carrier must seek reimbursement from the beneficiary. If the beneficiary has not yet recovered, the carrier must seek recovery from the third party directly. OPM, *Proposed Rule*, *Federal Employees Health Benefits Program; Subrogation and Reimbursement Recovery*, 80 Fed. Reg. 931, 932 (Jan. 7, 2015) (Pet. App. 150a).

As OPM has explained, these reimbursement and subrogation recoveries by carriers tend to reduce the premiums that the government and participants pay for the benefits that participants receive. *See Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 151a). That is true for both types of FEHBA carriers—experience-rated and community-rated: Recoveries by both types "lower subscription charges," merely by "different mechanism[s]." Pet. App. 170a-71a. Experience-rated carriers remit recoveries to the Fund; the recoveries are used to "increase [plan] benefits," reduce future premiums, or refund past premiums. 5 U.S.C. § 8909(a)-(b). Community-rated carriers may keep recovered funds, but must take prior recoveries into account when calculating future premiums. *See* OPM, *Community Rating Guidelines* 6, 11 (2015), http://tinyurl.com/zfwvhdt. Because "[t]he premiums that community-rated carriers charge generally depend on the expected cost of providing

benefits," these "recoveries by community-rated carriers tend to reduce those expected costs, and thus the premiums." Pet. App. 171a.

OPM has understood Section 8902(m)(1) "since Congress enacted it in 1978" to preempt state laws restricting subrogation or reimbursement recoveries. *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a); *accord* OPM, FEHB Program Carrier Letter No. 2012-18, at 1-2 (June 18, 2012) ("2012 Carrier Letter") (Pet. App. 117a-18a). OPM's contracts have long provided that carriers' subrogation and reimbursement obligations apply *regardless* of whether state law otherwise bars subrogation or reimbursement, so long as the carrier subrogates for one or more private employee-benefit plans governed by ERISA. *See, e.g.*, 2000 Standard Contract § 2.5. This ensures that FEHBA plans receive equal treatment with private-sector plans governed by ERISA—which this Court has held preempts state laws that preclude insurance administrators from seeking reimbursement, *see FMC Corp.* v. *Holliday*, 498 U.S. 52, 58-60 (1990).

4. OPM contracted with Coventry's predecessor to provide FEHBA benefits to federal employees in Missouri as a community-rated carrier. Pet. App. 45a. Coventry's contract provided that "[t]he applicable provisions of ... chapter 89 of title 5, United States Code [*i.e.*, FEHBA]" and "OPM's regulations as contained in part 890, title 5, Code of Federal Regulations, ... constitute a part of this contract," and that the contract's other provisions "shall be construed so as to comply" with those statutes and regulations. J.A.89. Any disputes over whether Coventry complied with its contract are governed by "United States law." J.A.234.

Coventry's contract further "direct[ed] [Coventry] to seek reimbursement or subrogation when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." Pet. App. 45a; J.A.120-21. Missouri common law "generally prohibits subrogation in personal injury cases by barring insurers from obtaining reimbursement from the proceeds an insured obtains following a judgment against a tortfeasor." Pet. App. 46a. Coventry's contract nevertheless required it to seek subrogation or reimbursement "in the same manner in which it subrogates claims for non-FEHB members," even in Missouri, because Coventry "subrogate[d] for at least one plan covered under" ERISA in Missouri. J.A.120-21; *see* J.A.77.

5. Respondent Jodie Nevils was a federal employee and participant in the Coventry plan in Missouri. Pet. App. 45a. He was injured in a car accident in 2006, and Coventry paid for his medical care. *Ibid.* Nevils also pursued a tort action against the driver responsible for his injury, and obtained a settlement. *Ibid.* Because Coventry's contract required it to seek reimbursement, it asserted (through a subcontractor) a lien on Nevils's settlement proceeds for $6,592.24, the amount Coventry had paid. *Ibid.* Nevils repaid that sum, satisfying the lien. *Ibid.*

Nevils then filed this class action against Coventry in Missouri state court, alleging that Missouri's common-law antisubrogation doctrine forbade Coventry from seeking reimbursement, and seeking (*inter alia*) actual and punitive damages. Pet. App. 45a; J.A.255, 259-63. Coventry removed the case to federal court, but it was remanded. Pet. App. 15a-27a.

Coventry sought summary judgment, arguing that FEHBA preempts Nevils's claims. Pet. App.

46a. The state circuit court granted summary judgment for Coventry, holding that FEHBA preempts Nevils's claims. *Id.* at 31a-32a. Nevils appealed, and the state court of appeals affirmed. *Id.* at 36a-43a.

6. The Missouri Supreme Court granted discretionary review. The United States filed an *amicus* brief supporting Coventry, arguing that FEHBA "[u]nambiguously [p]reempts" Missouri's antisubrogation doctrine. Pet. App. 175a; *id.* at 168a-85a. In 2014, the Missouri Supreme Court reversed in a divided decision ("*Nevils I*"). *Id.* at 46a-54a.

a. The majority held that Section 8902(m)(1) does not encompass state antisubrogation and antireimbursement laws. Pet. App. 46a-54a. It reasoned that *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677 (2006)—which addressed federal-court jurisdiction over reimbursement suits by FEHBA carriers—and a "presumption against preemption" require a narrow reading of Section 8902(m)(1). Pet. App. 48a-51a & n.1. The statute's "operative terms," the court held, "are 'relate to,' 'coverage' and 'benefits.'" *Id.* at 51a. It construed "relate to" as requiring a "direct and immediate relationship." *Id.* at 52a. It defined "coverage" as the "scope of the risks insured," without regard to subrogation or reimbursement recoveries, and "benefits" as *initial* payments participants receive before such recoveries. *Ibid.* Applying these definitions, the court held that FEHBA does "not preempt Missouri law barring subrogation" because subrogation "bears no immediate relationship to the nature, provision or extent of Nevils' insurance coverage and benefits" and affects only participants' "net financial position after the provision of insurance benefits." *Id.* at 53a.

b. Judge Wilson, joined by now-Chief Justice Breckenridge, concurred in the judgment. Pet. App. 55a-72a (Wilson, J., concurring in result). They "disagree[d]" with the majority's statutory interpretation, concluding that Section 8902(m)(1) plainly evinces Congress's intent to preempt antisubrogation and antireimbursement laws. *Id.* at 55a-56a, 59a-66a. "[B]enefit repayment terms," they explained, "are *related* to benefits because" an insured "does not care what his 'benefits' are if he will not be allowed to keep them"; and "terms requiring Nevils to *pay* benefits back to [Coventry] that [Coventry] previously had *paid* out ... relate to 'payment with respect to Nevils' benefits.'" *Id.* at 61a (brackets omitted).

Nevertheless, the concurring judges concluded that Section 8902(m)(1) does not preempt Missouri's antisubrogation law because (they opined) it is unconstitutional. Pet. App. 66a-71a. The statute, they asserted, violates the Supremacy Clause by "giv[ing] preemptive effect to the benefit repayment terms in [Coventry's] contract," not federal law. *Id.* at 67a.

7. Coventry sought certiorari, and this Court invited the United States' views. 135 S. Ct. 323 (2014). While Coventry's certiorari petition was pending, in January 2015, OPM commenced a notice-and-comment rulemaking to address the preemption issue. *Proposed Rule*, 80 Fed. Reg. at 931 (Pet. App. 148a). OPM proposed a regulation "reaffirm[ing]" OPM's longstanding position that subrogation and reimbursement provisions in FEHBA contracts "relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits)," and that FEHBA thus preempts state laws restricting such rights. *Id.* at 931-33 (Pet. App. 149a-53a). This interpretation, OPM explained, "comports

with longstanding Federal policy, lowers the cost of benefits, and creates greater uniformity in benefits and benefits administration." *Id.* at 932 (Pet. App. 149a). Subrogation and reimbursement recoveries also "lower subscription charges for individuals enrolled in" FEHBA plans. *Ibid.* (Pet. App. 150a). And OPM's reading "is consistent with the definition of subrogation and reimbursement ... and their relationship to benefits and the payment of benefits," and it "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." *Ibid.* (Pet. App. 151a).

After receiving public comments, OPM published its final rule in May 2015. *Final Rule*, 80 Fed. Reg. at 29,203 (Pet. App. 160a). The regulation mandates that "[a]ll health benefit plan contracts shall provide that the [FEHBA] carrier is entitled to pursue subrogation and reimbursement recoveries," and confirms that a carrier's "right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments." 5 C.F.R. § 890.106(a), (b)(1). Regarding preemption, the regulation states:

> A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.106(h). This regulation "formalizes OPM's longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978." *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a). That interpretation "applies to all FEHBA contracts," including "existing contracts." *Ibid.*

The United States thereafter filed its invited brief in this Court, explaining that *Nevils I* was "wrong" and "should be reversed." U.S. *Amicus* Br. 11-12, *Coventry Health Care of Mo., Inc.* v. *Nevils*, No. 13-1305 (U.S. May 22, 2015), 2015 WL 2457642. OPM's regulation, it argued, "adopt[ed] by far the best reading of the FEHB Act," "and, at a minimum, reasonably interpret[ed] a statute Congress charged OPM with administering," and is thus "entitled to the full measure of deference under *Chevron*." *Id.* at 12-13. The government recommended vacating and remanding for the state court to address that issue in the first instance. *Id.* at 11-12, 22. Adopting that suggestion, this Court granted certiorari, vacated, and remanded "for further consideration in light of [the] new regulations promulgated by [OPM]." 135 S. Ct. 2886 (2015).

8. On remand, Coventry urged the Missouri Supreme Court to revisit its reading of FEHBA, and at a minimum defer to OPM's regulation—and once again, the United States supported Coventry's position. Pet. App. 189a-203a. In a 2016 decision ("*Nevils II*"), the state court refused. *Id.* at 4a-13a.

a. The principal opinion, joined by five judges, declined to reconsider *Nevils I*'s analysis of the statute, and addressed only whether OPM's regulation changed the result. The majority acknowledged that OPM's construction of Section 8902(m)(1) was at least "plausible," and had "no doubt that there is

strong federal interest in regulating the provision of health insurance benefits for federal employees." Pet. App. 7a. The court nevertheless refused to accord any weight to OPM's interpretation. It asserted that this Court "has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause," and "[a]bsent binding precedent requiring such deference," the Missouri Supreme Court would not apply *Chevron*. *Id.* at 5a, 8a-12a.

Instead, the court again applied a presumption against preemption to construe Section 8902(m)(1) not to preempt state antisubrogation and antireimbursement laws. Pet. App. 6a-8a, 13a. "The fact that the FEHBA preemption clause is susceptible to alternate interpretations," it held, "counsels that preemption is warranted only if Congress expressed its clear and manifest intent that the purposes of FEHBA require the preemption of state antisubrogation laws." *Id.* at 7a.

b. Judge Wilson again concurred only in the judgment—joined again by Chief Justice Breckenridge, and this time by four other members of the court (who also joined the principal opinion). Pet. App. 14a (Wilson, J., joined by Breckenridge, C.J., and Fischer, Stith, Draper, and Russell, JJ., concurring in result); *id.* at 13a. Those six judges opined that, "for all the reasons stated in" Judge Wilson's "separate opinion" in *Nevils I*, Section 8902(m)(1) "is not a valid application of the Supremacy Clause," and therefore "does not displace Missouri law," because it purportedly "give[s] preemptive effect to the provisions of a contract between the federal government and a private party." *Id.* at 14a.

SUMMARY OF ARGUMENT

I. Section 8902(m)(1)—both by its terms, and as reasonably construed by OPM—preempts state laws that bar FEHBA carriers from seeking subrogation or reimbursement.

A. Section 8902(m)(1)'s text and purpose demonstrate unequivocally that Congress intended to preempt state laws restricting antisubrogation and antireimbursement recoveries by FEHBA carriers.

1. Section 8902(m)(1) expressly "supersede[s] and preempt[s]" state laws that impair "[t]he terms of any [FEHBA] contract ... which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). Laws restricting subrogation and reimbursement fall comfortably within that text. Subrogation and reimbursement provisions relate to the extent and provision of coverage and benefits because they make coverage and benefits *conditional* upon the carrier's right to recover the value of benefits it pays if a third party becomes obligated to pay the same costs. This Court's cases construing similar preemption clauses confirm this reading of FEHBA's plain text; indeed, the Court reached the same conclusion in the analogous context of private benefit plans governed by ERISA. *See FMC*, 498 U.S. at 58-60. At a minimum, subrogation and reimbursement relate to "payments with respect to benefits."

2. Congress's purposes in adopting (and expanding) Section 8902(m)(1) confirm this plain-text interpretation. As the United States explained in its prior briefing, antisubrogation and antireimbursement laws are "indistinguishable from the state mandated-benefit laws that Congress expressly targeted" in en-

acting that provision. Pet. App. 179a. Preempting state laws that restrict subrogation and reimbursement recoveries directly advances Congress's aim of facilitating uniform, fair administration of FEHBA plans nationwide. And it furthers Congress's goal of fostering cost efficiency, by preventing States from impeding carriers' cost-saving efforts.

3. Neither the presumption against preemption nor *McVeigh*, 547 U.S. 677, on which the Missouri Supreme Court relied, justifies its contrary interpretation. No such presumption applies to Section 8902(m)(1)—both because it is an *express*-preemption provision, and because it operates in a field implicating overriding federal interests in which the federal government has long regulated. Even where it properly applies, that presumption is merely a tie-breaking tool for resolving ambiguities, not a license to disregard clear statutory text and purpose.

Nor did *McVeigh*, as the court below believed, establish that Section 8902(m)(1) is ambiguous or must be construed narrowly. *McVeigh*'s holding concerned only federal-court *jurisdiction*. The Court expressly reserved judgment on the proper interpretation of Section 8902(m)(1), merely noting competing constructions that had been advanced principally by *amici* in that case, without choosing between them because they did not matter.

B. Even if FEHBA's text and purpose did not unambiguously resolve the question in Coventry's favor, OPM's reasonable statutory interpretation compels rejection of the judgment below. OPM's position, articulated in a notice-and-comment regulation promulgated pursuant to express statutory authority, is entitled to dispositive deference under *Chevron*. The decision below and Nevils conceded

that OPM's reading plausibly construes FEHBA's text, and neither disputed that it faithfully implements Congress's purposes.

The decision below instead refused to defer to OPM's position because it deemed *Chevron* categorically inapplicable to preemption clauses. This Court's precedent refutes that view. *Chevron* applies to *all* aspects of a statute an agency is charged with administering, *see City of Arlington* v. *FCC*, 133 S. Ct. 1863, 1874 (2013)—including the scope of a statute that preempts state law, *see, e.g.*, *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 743-44 (1996). The Missouri Supreme Court's view that the presumption against preemption trumps *Chevron* is backwards and irreconcilable with this Court's teaching.

II. Section 8902(m)(1) comports with the Supremacy Clause. The provision itself declares the state laws it covers "supersede[d] and preempt[ed]," simply defining the *scope* of preemption partly by reference to OPM's contracts. 5 U.S.C. § 8902(m)(1). It is thus the *statute* that displaces state law, to make room for FEHBA contracts to operate; that is all the Supremacy Clause requires. Federal statutes often preempt state laws by reference to particular types of contracts—from ERISA to the Federal Arbitration Act. The decision below would mean all of those statutes are constitutionally infirm also.

Even if Section 8902(m)(1) raised a serious constitutional question, it certainly *can* reasonably be read to mean that federal law has preemptive force. It therefore *must* be so construed to avoid, rather than create, a constitutional problem. The fair and efficient administration of the FEHBA Program depends on it.

ARGUMENT

I. FEHBA Preempts State Laws That Bar Carriers From Seeking Subrogation Or Reimbursement Recoveries.

Whether interpreted as an original matter, or construed in light of principles of administrative deference, FEHBA preempts state laws that restrict subrogation or reimbursement recoveries by FEHBA carriers. The Missouri Supreme Court's contrary conclusion contravenes the statute and this Court's precedent.

A. FEHBA Unambiguously Preempts State Laws Barring Subrogation Or Reimbursement By FEHBA Carriers.

The scope of preemption is, "at bottom," a question "of statutory intent." *Morales* v. *Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992). As with any statute, courts must discern Congress's intent by "'reading the whole statutory text, considering the purpose and context of the statute, and consulting any precedents or authorities that inform the analysis.'" *Kasten* v. *Saint-Gobain Performance Plastics Corp.*, 563 U.S. 1, 7 (2011) (citation omitted). All of those indicia demonstrate that Congress intended to preempt state laws that prevent FEHBA carriers from seeking subrogation or reimbursement. The deck-stacking presumption against preemption the decision below invoked is inapplicable, and in any event cannot overcome the overwhelming textual and contextual evidence of Congress's intent.

1. FEHBA's Text Unambiguously Preempts State Antisubrogation And Antireimbursement Laws.

Construing FEHBA's "pre-emption provision begins 'with the language of the statute itself,'" "'which necessarily contains the best evidence of Congress's pre-emptive intent.'" *Puerto Rico* v. *Franklin Cal. Tax-Free Tr.*, 136 S. Ct. 1938, 1946 (2016) (citations omitted). Because "'the statute's language'" here "'is plain,'" that "'is also where the inquiry should end.'" *Ibid.* (citation omitted).

Section 8902(m)(1) expressly "supersede[s] and preempt[s] any State or local law" that "relates to health insurance or plans" and that frustrates "[t]he terms of any [FEHBA] contract ... which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). State laws barring FEHBA carriers from seeking subrogation or reimbursement as required by their contracts fall squarely within that broad preemptive mandate. Antisubrogation and antireimbursement laws undisputedly "relat[e] to health insurance or plans." The only question is whether subrogation and reimbursement provisions "relate to" either "the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." *Ibid.* They do.

As this Court has "repeatedly recognized," the phrase "relates to" in preemption clauses "express[es] a broad pre-emptive purpose" with an "'expansive sweep.'" *Morales*, 504 U.S. at 383-84 (citation omitted); *accord Northwest, Inc.* v. *Ginsberg*, 134 S. Ct. 1422, 1428 (2014). Congress often employs that phrase (and indistinguishable variants) to reach everything that "'has a connection with, or reference

to,'" the topics the statute enumerates. *Morales*, 504 U.S. at 384 (citation omitted). Subrogation and reimbursement "relate to" the "extent" and "provision" of both "coverage" and "benefits" themselves, and to "payments with respect to benefits," in that sense.

a. Subrogation and reimbursement clauses relate to the "extent" and "provision" of employees' "coverage" and "benefits."

i. The ordinary meanings of those terms are undisputed. As the Missouri Supreme Court acknowledged, "coverage" in this context means "'the risks within the scope of an insurance policy,'" Pet. App. 52a (quoting *Black's Law Dictionary* 394 (8th ed. 2004) ("*Black's*"))—*i.e.*, in what circumstances, and under what conditions, the insurer has agreed to pay. *See also Webster's New International Dictionary* 613 (2d ed. 1949) ("*Webster's 2d*") ("The aggregate of risks covered by the terms of a contract of insurance."); *Webster's Third New International Dictionary* 525 (2002) ("*Webster's 3d*") ("protection by insurance policy"; "inclusion within the scope of a protective or beneficial plan"). And "benefits" in this setting refers to "'[f]inancial assistance that is received from ... insurance ... in time of sickness, disability, or unemployment.'" Pet. App. 52a (quoting *Black's* p. 167; omissions in original); *see also Webster's 2d* p. 253 ("Pecuniary help in time of sickness, old age, loss of employment, or the like"); *Webster's 3d* p. 204 (similar). The "extent" of coverage and benefits is simply the "amount ... extended," *i.e.*, their "size." *Webster's 2d* p. 900-01; *accord Webster's 3d* p. 805. And the "provision" of coverage and benefits means the "act or process of providing" them. *Webster's 3d* p. 1827; *accord Webster's 2d* p. 1995.

Subrogation and reimbursement clauses relate to both the extent (amount) and provision (process of providing) coverage and benefits because, by definition, such clauses make carriers' payments to participants "*conditional* upon a right to subrogation or reimbursement of equivalent amounts." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 150a) (emphasis added). If the FEHBA-plan participant has already recovered from a third party for the same costs, a reimbursement provision "require[s] the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided," 5 C.F.R. § 890.101(a), *i.e.*, to *pay back* some or all of the amount the carrier originally paid. If the participant has not yet recovered from a third party, a subrogation provision requires her to surrender her right to recover to the carrier—which becomes the "successor to the rights of" the participant. *Ibid.*

Subrogation and reimbursement rights relate to "coverage" because, by making carriers' payments *conditional* on recoveries (or rights to recover) from third parties, they limit the scope of risks an insurer takes on, and the circumstances in which the participant is entitled to have the carrier pay his medical costs. A carrier *without* subrogation and reimbursement rights undertakes a duty to bear those costs if any of the events listed in the policy occurs. A carrier *with* subrogation and reimbursement rights, in contrast, agrees to bear financial responsibility *only* if and to the extent those costs cannot be recouped from another source, such as a third-party tortfeasor.

For the same reason, subrogation and reimbursement rights relate to "benefits." The "financial assistance" a participant ultimately "receive[s]" from the carrier (*Black's* p. 167)—*i.e.*, the *net* amount she may retain under the terms and conditions of the contract—turns on whether and to what extent the carrier may seek reimbursement or subrogation. A reimbursement provision means the "enrollee's ultimate entitlement to benefit payments is *conditioned*" from the outset "upon providing reimbursement from any later recovery." *Helfrich* v. *Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1106 (10th Cir. 2015) (emphasis added). Similarly, when a carrier pursues subrogation, the "financial assistance" the participant received is effectively reduced by the value of the claim against the third party she surrenders to the carrier. "[R]eimbursement and subrogation provisions" thus "relate to ... 'benefits'" because they "are limitations on the payment of benefits." *Bell* v. *Blue Cross & Blue Shield of Okla.*, 823 F.3d 1198, 1203 (8th Cir. 2016) (omission in original).

Coventry's contract here, for example, "direct[ed] [Coventry] to seek reimbursement ... when an insured obtains a settlement or judgment against a tortfeasor for payment of medical expenses." Pet. App. 45a; J.A.120-21. Because Nevils obtained a settlement with a third party for his injuries, he was obligated to reimburse Coventry to the extent he recovered from the tortfeasor on account of his injuries. The amount of "benefits" Nevils is entitled to *keep* is the sum Coventry originally paid *minus* the sum Nevils had to *repay*. The gravamen of Nevils's claim is that Coventry in effect wrongfully retained benefits to which Nevils claims he is entitled. *See* J.A.260-61; *cf. Buckner* v. *Heckler*, 804 F.2d 258, 259-60 (4th Cir. 1986) (per curiam) (Medicare partici-

pant's "claim that she is entitled to [an] overpayment" claimed by Medicare intermediary under reimbursement provision "is, in essence, one for [M]edicare benefits").

At a minimum, subrogation and reimbursement rights "'ha[ve] a connection with, or reference to'" (*Northwest*, 134 S. Ct. at 1428 (citation omitted)) the "extent" and "provision" of coverage and benefits, which is all FEHBA requires. Such rights are *triggered* only if the carrier previously advanced payment on account of medical treatment—*i.e.*, provided benefits—for which the plan provided coverage, and for which a third party (such as a tortfeasor) is also responsible. And the sum a carrier may recoup depends on the *amount* of that payment. Subrogation and reimbursement clauses thus fall squarely within Section 8902(m)(1)'s plain terms.

ii. This Court has already concluded that reimbursement rights "relat[e] to" employee "benefits" in the closely analogous context of *private* employee-benefit plans governed by ERISA. *See FMC*, 498 U.S. at 58-60. ERISA's parallel preemption clause "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). *FMC* held that this preemption clause encompasses "antisubrogation law[s]" that "prohibi[t] plans from ... requiring reimbursement." 498 U.S. at 58, 60. Such laws "'relat[e] to' an employee benefit plan" because reimbursement affects how carriers "calculate benefit levels." *Ibid.* Laws barring reimbursement "requir[e] plan providers to calculate benefit levels in" States that have such laws "based on expected liability conditions that differ from those in States" that do not, changing the net amount carriers are obligat-

ed to pay. *Id.* at 60. That disparity "frustrate[s] plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Ibid.*

FMC's reasoning is fully applicable to FEHBA. As multiple courts have recognized, given the parallels between the texts and contexts of ERISA's and FEHBA's "nearly identical" preemption clauses, *Pharm. Care Mgmt. Ass'n* v. *Rowe*, 429 F.3d 294, 299 n.2 (1st Cir. 2005) (per curiam), "precedent interpreting the ERISA provision" is "authority for cases involving the FEHBA provision," *Botsford* v. *Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *see also, e.g.*, *Aybar* v. *N.J. Transit Bus Operations, Inc.*, 701 A.2d 932, 935-36 (N.J. App. Div. 1997). If anything, *FMC*'s reasoning applies with even greater force to FEHBA—which concerns benefits not of *private* workers, but *federal* employees. There is certainly no reason to construe FEHBA's preemption provision more *narrowly* than ERISA's parallel provision. As the United States has explained, "[i]t is exceedingly unlikely that Congress intended a *broader* role for state law," or "desired *less* uniformity," "in the case of federal employees than in the case of private employees." Pet. App. 178a (emphases added).

iii. The Missouri Supreme Court acknowledged that subrogation and reimbursement rights are "triggered by the payment of benefits" and "affec[t] the parties' net financial position." Pet. App. 53a. It nevertheless concluded that subrogation and reimbursement do not "relate to" the "extent" or "provision" of "coverage" or "benefits." *Id.* at 1a-2a, 52a-54a. Its reasoning contradicts FEHBA and this Court's case law.

The court below asserted that "relate to" requires a "direct and immediate relationship" to coverage and benefits. Pet. App. 52a. It did not attempt, however, to square that construction with this Court's decisions expansively construing "relate to" in preemption clauses generally. And it never confronted *FMC*'s application of ERISA's parallel provision to reimbursement rights specifically.

The Missouri Supreme Court's application of its narrow reading of "relate to," moreover, is unsupportable. The court posited that reimbursement and subrogation rights lack a "direct and immediate relationship" to coverage or benefits because such rights do not change the amount that carriers pay *initially* on account of participants' injuries. Pet. App. 52a-53a; *see id.* at 1a-2a. That facile distinction between what an employee originally receives and what he ultimately keeps is illusory and defies economic logic. Nothing in the definitions of "coverage" and "benefits" (including those the court cited) supports focusing exclusively on the amount participants receive initially without regard to repayments that reduce that sum. And what matters to all concerned—participants, carriers, and OPM—is the *net* amount the carrier must pay, *i.e.*, the value the participant can ***keep***, which represents the true economic risk assumed by the carrier.

This Court has rejected similar ersatz distinctions in other preemption contexts. In *Northwest*, it held that a state-law claim concerning frequent-flyer miles used to reduce the prices consumers pay for flights and upgrades "'relate[d] to'" an airline's "'rates, routes, or services,'" and thus was preempted by the Airline Deregulation Act, 49 U.S.C. § 41713. 134 S. Ct. at 1430-31 (citation omitted). "[T]he fre-

quent flyer program," *Northwest* held, was "connected to the airline's 'rates'" because it affected the *net* prices program participants paid for airline services: "When miles are used" to obtain "tickets and upgrades," "the rate that a customer pays, *i.e.*, the price of a particular ticket, is either eliminated or reduced." *Id.* at 1428, 1431 (citation omitted). "The program" was "also connected to 'services,' *i.e.*, access to flights and to higher service categories." *Id.* at 1431. The plaintiff urged that his claim concerned only his frequent-flyer-program status *itself*, not access to or prices of flights and upgrades. *Ibid.* But that "proffered distinction," this Court held, "has no substance": The obvious goal of the plaintiff's claim was "to obtain reduced rates and enhanced services." *Ibid.*

Even apart from sweeping "related to" preemptive language, this Court has rejected similar distinctions advanced to evade preemption. In *Hillman* v. *Maretta*, 133 S. Ct. 1943 (2013), the Court addressed a federal statute regarding the analogous context of federal employees' life-insurance benefits. The Court held that the statute's provision prescribing who receives life-insurance payments impliedly preempted a state law directing recipients of life-insurance payments to transfer them to someone else. *Hillman* expressly rejected a purported distinction between the *initial* payment of benefits and a later *transfer* of benefit payments. *See id.* at 1952. It "makes no difference," the Court held, whether state law withholds benefits in the first instance or instead takes them away after they have been paid: "In either case, state law displaces the beneficiary selected" under federal law. *Ibid.*

b. Even if subrogation and reimbursement did not relate to coverage and benefits, state laws restricting subrogation and reimbursement still are preempted by another phrase in Section 8902(m)(1). FEHBA also explicitly protects from state-law interference terms related to the extent or provision of "*payments with respect to* benefits." 5 U.S.C. § 8902(m)(1) (emphasis added). That text unquestionably covers subrogation and reimbursement rights.

Subrogation and reimbursement recoveries themselves *are* "payments with respect to benefits": When a carrier exercises either right, it receives a "payment"—from the participant or a third party—"with respect to benefits" previously paid. At a minimum, as the United States has explained, subrogation and reimbursement "rights *relate to* benefit payments because they require a beneficiary to return benefits to the extent the beneficiary has been separately reimbursed for those benefits from a tort recovery." Pet. App. 176a (emphasis added); *accord Bell*, 823 F.3d at 1204. The whole point of subrogation and reimbursement is to facilitate *repayments* of benefits. Their practical effect is to *undo or reduce* a prior benefit payment. If these rights do not relate to payments with respect to benefits, nothing does.

Both Coventry and the United States brought FEHBA's "payments with respect to benefits" phrase to the Missouri Supreme Court's attention. Coventry Mo. S. Ct. Br. 38-40 (Nov. 16, 2015); Pet. App. 176a-77a. The court, however, never confronted this independently dispositive text. And its interpretation—focused exclusively on what a participant initially receives without regard to later repayments—reads "payments with respect to benefits" out of the stat-

ute. That reading contravenes courts' duty to "'have regard to *all* the words used by Congress,'" *United States* v. *Atl. Research Corp.*, 551 U.S. 128, 137 (2007) (emphasis added) (citation omitted), and to "'give effect, if possible, to every clause and word,'" *Duncan* v. *Walker*, 533 U.S. 167, 174 (2001) (citation omitted).

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Because the "'language'" of FEHBA's preemption clause "'is plain,'" the analysis ends where it begins: with the "'plain wording of the clause.'" *Franklin*, 136 S. Ct. at 1946 (citation omitted). By FEHBA's plain terms, state laws restricting subrogation and reimbursement are preempted.

2. Congress's Purposes Confirm That FEHBA Preempts Antisubrogation And Antireimbursement Laws.

Additional evidence of Congress's "purpose"—the "'ultimate touchstone' of pre-emption analysis," *Wis. Dep't of Indus., Labor & Human Relations* v. *Gould Inc.*, 475 U.S. 282, 290 (1986) (citation omitted)—cements this natural reading of FEHBA's text. "Statutory construction ... is a holistic endeavor," and even "[a] provision that may seem ambiguous in isolation" may be "clarified by the remainder of the statutory scheme," including where "only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." *United Sav. Ass'n of Tex.* v. *Timbers of Inwood Forest Assocs.*, 484 U.S. 365, 371 (1988). Congress's manifest purposes in enacting FEHBA's preemption provision erase any possible doubt about its application here.

Congress originally enacted Section 8902(m)(1) to combat state-law interference with FEHBA plans. H.R. Rep. No. 95-282, at 2-5 (J.A.353-57); S. Rep. No. 95-903, at 2-5 (J.A.366-71); H.R. Rep. No. 94-1211, at 2-4 (J.A.337-40). Congress feared that divergent state-law requirements—including laws mandating particular benefits—would result in "[i]ncreased premium costs to both the Government and enrollees, and [a] lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States." H.R. Rep. No. 95-282, at 4 (J.A.355); *see also* S. Rep. No. 95-903, at 2 (J.A.366). After years of additional experience, Congress *broadened* Section 8902(m)(1) "to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live," and to "prevent carriers' cost-cutting initiatives from being frustrated by State laws." H.R. Rep. No. 105-374, at 9 (J.A.403); *see also* S. Rep. No. 105-257, at 9, 14-15 (J.A.456, 468).

Construing Section 8902(m)(1) to preempt laws barring FEHBA carriers from seeking subrogation and reimbursement directly "furthers Congress's goals of reducing health care costs and enabling uniform, nationwide application of FEHB contracts." *Final Rule*, 80 Fed. Reg. at 29,203 (Pet. App. 159a-60a). Subrogation and reimbursement recoveries yield substantial cost savings—"approximately $126 million" in 2014 alone—which "translate to premium cost savings for the federal government" (thus taxpayers) "and FEHB enrollees." *Ibid.*; *see also Helfrich*, 804 F.3d at 1106-07. That interpretation also directly advances the "strong federal interest in national uniformity in coverage and benefits," which

"include[s] uniform administration of the FEHB program across state lines." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 152a). Achieving that interest necessitates "uniform rules that affect the rights and obligations of enrollees in a given plan without regard to where they live." *Ibid.* As the United States has explained, "Missouri's anti-subrogation rule is indistinguishable from the state mandated-benefit laws that Congress expressly targeted with the enactment of the FEHBA preemption provision," as it "requires FEHB providers to provide Missouri consumers with FEHB benefits that consumers in other states do not receive under the terms of the same FEHB contract." Pet. App. 179a.

Reading FEHBA *not* to preempt state antisubrogation and antireimbursement laws, in contrast, would thwart Congress's aims. That view would invite a motley patchwork of State-specific restrictions that "is administratively burdensome, gives rise to uncertainty and litigation, and results in treating enrollees differently, although enrolled in the same plan and paying the same premium." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 152a). Such inconsistency would not only hamstring the cost-cutting efforts that Congress specifically intended to encourage, but also would be unfair to FEHBA enrollees. If state laws forbidding subrogation or reimbursement recoveries "surviv[e] preemption," the United States has explained, "the loser[s] will be FEHB enrollees in states that permit" those recoveries, "who will be subsidizing the more generous benefits that" such laws "effectively mandat[e] that FEHB carriers provide." Pet. App. 179a. This "cross-subsidization" unfairly advantages some participants at the expense of others, merely because of where they live, "creat[ing]

precisely the disuniformity that Congress intended to preclude." *Ibid.*

Indeed, as the government explained below, the clash between Congress's objectives and state laws restricting FEHBA carriers' ability to seek subrogation and reimbursement as their contracts require is so stark that such laws would be preempted even if FEHBA did not *expressly* displace them. Pet. App. 180a (citing *Arizona* v. *United States*, 132 S. Ct. 2492, 2505 (2012)). Independent of express preemption, state laws that pose "'an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'" are impliedly preempted. *Hillman*, 133 S. Ct. at 1950 (citation omitted). Regardless of whether a statute contains an express-preemption clause, state laws that "'frustrat[e] the deliberate purpose of Congress'" may be preempted on that separate basis. *Id.* at 1949-55 (citation omitted) (holding state law impliedly preempted without addressing express preemption); *see also Geier* v. *Am. Honda Motor Co.*, 529 U.S. 861, 869 (2000). *A fortiori*, in construing the express-preemption provision that Congress *did* enact, Congress's purposes preclude according that provision an artificially narrow meaning that is at war with Congress's aims.

Congress's objectives in adopting and expanding FEHBA's express-preemption provision thus forcefully corroborate the best reading of its language. Even if Section 8902(m)(1)'s text in a vacuum could *also* plausibly bear the Missouri Supreme Court's crabbed construction, Congress's purposes in enacting it foreclose that reading. Yet the court below never confronted those purposes—in either of its decisions—let alone explained how its narrow reading could be squared with Congress's objectives.

3. Neither The Presumption Against Preemption Nor *McVeigh* Supports A Contrary Reading Of FEHBA.

The Missouri Supreme Court tellingly did *not* contend that FEHBA's plain language or Congress's objectives compelled a contrary interpretation. Instead, relying on dictum in *McVeigh*, 545 U.S. 677, the court declared FEHBA's preemption provision "ambiguous" and applied a presumption against preemption to resolve that putative ambiguity. Pet. App. 3a, 5a-7a, 47a-48a. That conclusion is incorrect because both of the state court's premises are wrong: The presumption against preemption has no application to FEHBA's preemption provision. In any event, Section 8902(m)(1) contains no genuine ambiguity that the presumption could resolve. *McVeigh* did not establish otherwise.

a. In both its 2014 and 2016 decisions, the Missouri Supreme Court commenced its "preemption analysis ... 'with the basic assumption that Congress did not intend to displace state law.'" Pet. App. 6a (citation omitted); *id.* at 47a-48a. That assumption has no place in construing FEHBA's preemptive scope.

The presumption against preemption is irrelevant because Section 8902(m)(1) is an *express*-preemption provision. Where a "statute 'contains an express pre-emption clause,'" courts "do *not* invoke any presumption against pre-emption," but "instead 'focus on the plain wording of the clause.'" *Franklin*, 136 S. Ct. at 1946 (emphasis added) (citation omitted). There is no reason to construe an express-preemption provision narrowly to avoid trenching inadvertently on state prerogatives; by definition, such provisions demonstrate that Congress *inten-*

tionally displaced state laws. The only question is *which* ones—and on that score, the statutory text is the best guide to Congress's intent. *See ibid.*

The presumption is independently inapposite because FEHBA addresses an area of overwhelmingly federal interests with a lengthy history of federal regulation. The presumption is merely a starting "assum[ption]" that, "[i]n areas of *traditional state regulation*," state law is not preempted "unless Congress has made such an intention 'clear and manifest.'" *Bates* v. *Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005) (emphasis added) (citation omitted). The presumption thus "is not triggered" in areas where the "interests at stake are 'uniquely federal' in nature," *Buckman Co.* v. *Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001) (citation omitted), or "where there has been a history of significant federal presence," *United States* v. *Locke*, 529 U.S. 89, 108 (2000); *see also Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016). Both are true of the provision of federal-employee benefits.

"[T]he relationship between a federal agency and the entity it regulates is inherently federal in character because the relationship originates from, is governed by, and terminates according to federal law." *Buckman*, 531 U.S. at 347. That is especially true of FEHBA, which "governs only contracts for the benefit of federal employees." *Helfrich*, 804 F.3d at 1105. Those contracts "concer[ning] benefits from a *federal* health insurance plan for *federal* employees that arise from a *federal* law" implicate "'[d]istinc[t] *federal* interests.'" *Bell*, 823 F.3d at 1202 (emphases added) (citation omitted). "The scope of a federal employee's reimbursement obligations," for instance, "has a significant impact on the federal treasury and

on premiums or benefits for other employees." *Ibid.*; *see* 5 U.S.C. § 8909(b); 5 C.F.R. § 890.503(c)(2). Even the decision below had "no doubt" that "regulating the provisions of health insurance benefits for federal employees" implicates a "strong federal interest." Pet. App. 12a. Given these overriding federal interests, "[t]he federalism concern (respecting state sovereignty) behind the presumption" thus "has little purchase" here. *Helfrich*, 804 F.3d at 1105.

It is also "an understatement to say that 'there has been a history of significant federal *presence*' in the area of federal employment" and federal-employee benefits. *Helfrich*, 804 F.3d at 1105 (emphasis added) (citation omitted). "Congress has legislated on the matter from the outset." *Ibid.* Congress *created* the FEHBA Program nearly six decades ago. The Program has been governed ever since by a federal statute and by regulations and contract terms prescribed by a federal agency. And from 1978 forward, *state* law has been explicitly displaced. Given this "obviously ... long history of federal involvement in federal employment and benefits," there is no basis to assume that, in preempting state law, Congress intended to tread lightly—and consequently no "warrant to place a thumb on the scales against [the] preemptive effect of" Section 8902(m)(1). *Bell*, 823 F.3d at 1202.

b. Even if the presumption against preemption did apply, it could not justify the Missouri Supreme Court's distortion of Section 8902(m)(1). The presumption is not a command to construe the preemptive reach of federal statutes narrowly at all costs. Even "[i]n areas of traditional state regulation" where it applies, the presumption is merely a tie-breaking tool for resolving ambiguities—a default

rule for selecting between otherwise-plausible interpretations of a statute's scope. *Bates*, 544 U.S. at 449. Where Congress "'*has* made [its] intention'" to preempt certain state laws "'clear and manifest,'" the presumption cannot override that intention. *Ibid.* (emphasis added) (citation omitted). Even "state laws 'governing'" issues of paradigmatic state concern—such as "family law"—"'must give way to clearly conflicting federal enactments,'" the presumption notwithstanding. *Hillman*, 133 S. Ct. at 1950 (citation omitted).

The presumption thus has no bearing on whether FEHBA preempts antisubrogation and antireimbursement laws because the statute speaks clearly; there is no tie to break. The only reading of Section 8902(m)(1) that is faithful to its text and purpose—and by far the most persuasive—is that it does supersede such laws. *Supra* pp. 23-35. Even if the Missouri Supreme Court's contrary reading were colorable, the presumption cannot elevate what is at best a barely tenable construction over a vastly more plausible reading of FEHBA's text and context.

Indeed, although the Missouri Supreme Court pronounced Section 8902(m)(1) "ambiguous" and subject to multiple "plausible readings," Pet. App. 3a, 47a-48a, it never undertook to demonstrate that its *own* interpretation is equally plausible. Instead, the court deemed Section 8902(m)(1) ambiguous based on dictum in *McVeigh*, 547 U.S. 677, and read that decision to require a narrow reading of FEHBA's preemptive scope. Pet. App. 3a-4a, 48a-51a. The Missouri Supreme Court badly misread *McVeigh*.

The only issue *McVeigh* decided concerned federal-court *jurisdiction* over FEHBA carriers' reimbursement actions—*i.e.*, "the proper *forum*" for

FEHBA carriers to seek reimbursement of duplicative benefits as their contracts require—not *whether* they may seek reimbursement despite state law. 547 U.S. at 682 (emphasis added). In *McVeigh*, a FEHBA carrier sued in federal court, seeking reimbursement from a participant who received plan benefits but also recovered from a third party. *Id.* at 683. The question presented in this Court was whether the carrier's claims "'ar[ose] under'" federal law so as to support jurisdiction under 28 U.S.C. § 1331. 547 U.S. at 683, 688 (citation omitted). Ordinarily, "[t]he presence or absence of federal-question jurisdiction" is judged based on the "face of the plaintiff's properly pleaded complaint," and "federal pre-emption is ... a defense." *Caterpillar Inc.* v. *Williams*, 482 U.S. 386, 392 (1987). But "the pre-emptive force of" some statutes "is so 'extraordinary'" that it not only displaces all state law in the field but also "'converts'" any purported state-law claim into a federal one, providing a federal forum for its adjudication. *Id.* at 393 (citations omitted). The carrier in *McVeigh* argued that its complaint "'state[d] a federal claim'" under this doctrine. 547 U.S. at 693 (citation omitted). Over the dissent of four Justices, the Court held federal jurisdiction lacking. *Id.* at 689-701; *cf. id.* at 702-14 (Breyer, J., joined by Kennedy, Souter, and Alito, JJ., dissenting).

In addressing that jurisdictional issue, the majority noted two alternative interpretations of Section 8902(m)(1) advanced principally by two *amici*. 547 U.S. at 697. The United States urged that reimbursement is a "condition or limitation on benefits received by a federal employee," and therefore does relate to "'coverage or benefits' and 'payments with respect to benefits.'" *Ibid.* (citing U.S. *Amicus* Br. 20, *McVeigh*, No. 05-200 (U.S. Feb. 24, 2006), 2006 WL

467692). An *amicus* supporting the FEHBA-plan participant, in contrast, asserted that "'coverage' and 'benefits'" refer only to "contract terms relating to the beneficiary's entitlement (or lack thereof) to Plan payment for certain healthcare services," but "not to terms relating to the carrier's postpayment right to reimbursement." *Ibid.* (citing Julia Cruz *Amicus* Br. 10-11, *McVeigh*, No. 05-200 (Mar. 31, 2006), 2006 WL 927237).

After noting these two proffered interpretations, *McVeigh* expressly reserved judgment on them because they had no bearing on the jurisdictional question. 547 U.S. at 698. "To decide this case," the Court explained, it "need not choose between those plausible constructions," because federal jurisdiction would not exist *either way*: Regardless of whether FEHBA preempts state laws restricting reimbursement and subrogation, it does not create a freestanding federal cause of action. *Ibid.* The Court accordingly undertook no analysis of which reading of Section 8902(m)(1) is more faithful to its text, Congress's purpose, and this Court's precedent; there was no need. Instead, consistent with the well-settled "dictate of wisdom and judicial propriety to decide no more than is necessary to the case in hand," *Trade-Mark Cases*, 100 U.S. 82, 96 (1879); *see also, e.g.*, *Samsung Elecs. Co.* v. *Apple Inc.*, __ U.S. __, 2016 WL 7078449, at *6 (Dec. 6, 2016), the Court expressed no opinion on Section 8902(m)(1)'s scope. It merely described two competing constructions advocated by litigants, and explained their irrelevance to the question presented.

Properly understood, *McVeigh* does not establish anything about the correct interpretation of Section 8902(m)(1)—as other courts have consistently recog-

nized, *see, e.g.*, *Bell*, 823 F.3d at 1203; *López-Muñoz* v. *Triple-S Salud, Inc.*, 754 F.3d 1, 6 (1st Cir. 2014); *Pellicano* v. *Blue Cross Blue Shield Ass'n*, 540 F. App'x 95, 98-99 (3d Cir. 2013) (per curiam). The Court did not hold that FEHBA's preemption provision is ambiguous at all. Even read for all it might be worth, *McVeigh*'s passing description in dictum of competing interpretations as "plausible" in the abstract hardly justifies declaring Section 8902(m)(1)'s words a wash and invoking the presumption against preemption to pick the narrower reading. "[T]o acknowledge ambiguity is not to conclude that all interpretations are *equally* plausible." *Gwaltney of Smithfield, Ltd.* v. *Chesapeake Bay Found., Inc.*, 484 U.S. 49, 57 (1987) (emphasis added). *McVeigh* certainly did not hold that the two interpretations the Court described are in equipoise. Even if the Missouri Supreme Court's reading of FEHBA were in the ballpark (and it is not), the statute's text and Congress's readily apparent purpose point decidedly in favor of preemption.

B. OPM's Reasonable Interpretation Of FEHBA Controls Under *Chevron*.

OPM's 2015 regulation construing FEHBA to preempt state antisubrogation and antireimbursement laws independently compels adopting that construction here and reversing the decision below. Indeed, although OPM's statutory interpretation is correct, to decide this case the Court need not determine whether any other constructions are also (or even equally) plausible. Regardless of whether FEHBA is clear or ambiguous, all that matters under this Court's precedent is that OPM's reading of a statute it administers is *reasonable*. OPM's interpretation easily clears that threshold, and therefore controls.

The Missouri Supreme Court expressly refused to defer to OPM's interpretation of FEHBA. But it did not dispute that OPM's reading is reasonable. The court withheld deference instead based on the mistaken premise that *Chevron* is categorically inapplicable to preemption clauses in federal statutes. This Court's case law refutes that misunderstanding.

1. OPM's Interpretation Of FEHBA Is Reasonable And Merits Deference.

It is blackletter law that a federal agency's reasonable interpretation of a federal statute it administers governs under *Chevron*, 467 U.S. at 843-44, at least when articulated through "administrative action with the effect of law," such as "notice-and-comment rulemaking," *United States* v. *Mead Corp.*, 533 U.S. 218, 230 (2001). Congress may "express[ly] delegat[e]" an issue to an agency's discretion, or may do so "implicit[ly]," by not addressing the issue directly in the statute's text. *Chevron*, 467 U.S. at 843-44. Either way, "a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id.* at 844. When Congress "le[aves] ambiguity in a statute," courts "presum[e]" Congress "understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows." *Smiley*, 517 U.S. at 740-41. The agency's "view governs if it is a reasonable interpretation of the statute"—whether or not it is "the only possible interpretation," or "even the interpretation deemed *most* reasonable by the courts." *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 (2009). That applies to "*all* the matters the agency is

charged with administering." *City of Arlington*, 133 S. Ct. at 1874.

Straightforward application of *Chevron* resolves this case. Congress authorized OPM to administer FEHBA by "prescrib[ing] regulations necessary to carry out" the statute, 5 U.S.C. § 8913(a), and by establishing "definitions of benefits," including "limitations" and "exclusions," in its contracts, *id.* § 8902(d). OPM articulated its position in a notice-and-comment rule carrying the force of law, which speaks directly to the question here. *Final Rule*, 80 Fed. Reg. at 29,204-05 (Pet. App. 167a). It provides that "[a]ny FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage"—thus defining benefits as subject to this condition. 5 C.F.R. § 890.106(b)(1). It concludes that "[a] carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1)"—and that those "rights and responsibilities are therefore effective notwithstanding any state or local law." *Id.* § 890.106(h).

Under *Chevron*, OPM's interpretation controls so long as it is "reasonable." *Entergy*, 556 U.S. at 218 & n.4. This Court, in fact, need not even decide whether FEHBA unambiguously compels OPM's interpretation, or instead might plausibly bear some other reading; so long as the interpretation *OPM* has adopted is at least "reasonable," it "governs." *Ibid.*

There is not, and cannot be, any serious dispute that OPM's interpretation of Section 8902(m)(1) is at least reasonable. OPM's position is by far the most persuasive reading of FEHBA's plain language, and the only interpretation faithful to Congress's purposes. *Supra* pp. 23-35. Both the decision below and Nevils *conceded* that OPM's reading of FEHBA's text is "plausible." Pet. App. 3a; Nevils Mo. S. Ct. Br. 31, 36 (Oct. 6, 2015). And neither disputed that OPM's interpretation is otherwise consistent with Congress's "expressed intent." *Rust* v. *Sullivan*, 500 U.S. 173, 184 (1991) (agency's position is entitled to *Chevron* deference "if it reflects a plausible construction of the plain language of the statute and does not otherwise conflict with Congress' expressed intent").

OPM's experience and expertise administering the Program bolster the reasonableness of its interpretation. "As the agency that has negotiated FEHBA contracts for federal employees for years, OPM has deep knowledge of the impact and interrelationships of contractual provisions." *Helfrich*, 804 F.3d at 1109-10. The agency is particularly well-positioned to assess the adverse effects of allowing state antisubrogation and antireimbursement laws to interfere with FEHBA contracts.

The consistency of OPM's position over many years entitles it to still greater weight. While *Chevron* applies regardless of when OPM first adopted the position reflected in its regulation (or even if it previously had taken a different view), *see Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 981 (2005), the "consisten[cy]" of OPM's interpretation and "[t]he length of time" it has maintained that position reinforce its reasonableness. *Kasten*, 563 U.S. at 15-16. OPM's 2015

regulation codifies the agency's "longstanding interpretation of what Section 8902(m)(1) has meant since Congress enacted it in 1978." *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a). OPM "has consistently taken the position that the FEHB Act preempts state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts." *Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 153a); *see also* 2012 Carrier Letter 1-2 (Pet. App. 116a-18a).

Indeed, even *before* Congress enacted FEHBA's express-preemption provision, OPM's predecessor, the Civil Service Commission, made clear its view that "'the Federal Employees Health Benefits Act preempts state laws in this area.'" H.R. Rep. No. 95-282, at 3 (J.A.354) (citation omitted). Concerned that the absence of an express-preemption provision would make "'enforcement of this preemption policy'" both "'time consuming and costly,'" *ibid.* (citation omitted), and to ensure the agency had "clear authority to issue regulations" addressing the scope of preemption, Congress enacted Section 8902(m)(1) in 1978. S. Rep. No. 95-903, at 4 (J.A.370). OPM, created the same year, has understood the statute ever since to preempt state antisubrogation and antireimbursement laws. *Final Rule*, 80 Fed. Reg. at 29,204 (Pet. App. 162a).

OPM's interpretation of FEHBA in its regulation is at a minimum reasonable. It therefore merits dispositive deference under *Chevron*. *See Kobold* v. *Aetna Life Ins. Co.*, 370 P.3d 128, 130-32 (Ariz. Ct. App. 2016), *review denied*, No. CV-16-0082-PR (Ariz. Oct. 19, 2016). Even if OPM's regulation did not merit full-fledged *Chevron* deference, it still would be entitled to significant weight, given OPM's

"longstanding and persuasively explained" reading, *Helfrich*, 804 F.3d at 1109-10, and its "'experience and informed judgment'" administering FEHBA, *Fed. Exp. Corp.* v. *Holowecki*, 552 U.S. 389, 399 (2008) (quoting *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 139-40 (1944); other citation omitted); *see Helfrich*, 804 F.3d at 1109-10 & n.11 ("we would adopt OPM's conclusion" "even under [*Skidmore*'s] less deferential standard"). The respect due to OPM's expert, longstanding position resolves any possible ambiguity FEHBA might be read to contain.

2. The Missouri Supreme Court Had No Basis To "Decline" To Apply *Chevron*.

The Missouri Supreme Court refused to accord OPM's position *any* weight. Pet. App. 5a-12a, 54a n.2. It asserted that *this* Court "has never held expressly that *Chevron* deference applies to resolve ambiguities in a preemption clause," and, in the "[a]bsen[ce]" of "binding precedent *requiring* such deference," it "decline[d]" to apply *Chevron* in construing Section 8902(m)(1). *Id.* at 5a (emphasis added). In the state court's view, *Chevron* could not overcome the presumption against preemption that the court held applicable. That invented carve-out from *Chevron* is irreconcilable with this Court's case law.

a. This Court has flatly rejected the assertion that *Chevron* applies piecemeal to some topics under a statute but not others. *See City of Arlington*, 133 S. Ct. at 1874. Where an agency is authorized to interpret a statute, "the whole includes all of its parts," and *Chevron* "validate[s] rules for *all* the matters the agency is charged with administering." *Ibid.* There are "no 'exception[s]'" to *Chevron*, this

Court made clear, for any "'legal questions concerning the coverage' of an Act." *Id.* at 1871 (brackets and citation omitted). Indeed, there has not been "a single case" in which a court held "a general conferral" of rulemaking authority "insufficient to support *Chevron* deference for an exercise of that authority within the agency's substantive field." *Id.* at 1874. "[T]he preconditions to deference under *Chevron* are satisfied," in short, so long as "Congress has unambiguously vested [an agency] with general authority to administer [the statute] through rulemaking ... , and the agency interpretation at issue was promulgated in the exercise of that authority." *Ibid.*

City of Arlington forecloses creating any exception to *Chevron* here. FEHBA explicitly authorizes OPM to "prescribe regulations necessary to carry out this chapter"—*viz.*, Chapter 89 of Title 5, the entirety of FEHBA. 5 U.S.C. § 8913(a). That authorization empowered OPM to interpret *every* aspect of the statute—including Section 8902(m)(1).

The Missouri Supreme Court dismissed *City of Arlington* as "not a Supremacy Clause case." Pet. App. 11a. But the case concerned the Federal Communications Commission's interpretation of a federal statute that places restrictions on the regulatory authority of *state and local governments*—several of which were petitioners in this Court. 133 S. Ct. at 1866-67. Indeed, the Court specifically noted that it had previously "deferred to the FCC's assertion that its broad regulatory authority extends to preempting conflicting state rules." *Id.* at 1871. More fundamentally, *City of Arlington*'s central holding is that there are *no* subject-matter-specific exceptions to *Chevron*. *Id.* at 1868-75. The Missouri Supreme

Court's attempt to limit that case to a particular topical area eviscerates that holding.

b. This Court's decisions, moreover, have repeatedly made clear that *Chevron* applies to the interpretation of preemption provisions specifically. The court below distorted or disregarded those decisions.

i. In *Smiley*, this Court expressly held that *Chevron* applies to an agency's interpretation of the "meaning" of a provision that "pre-empts state law." 517 U.S. at 744. *Smiley* concerned a regulation issued by the Comptroller of the Currency construing a provision of the National Bank Act, 12 U.S.C. § 85. The Court had previously held (in *Marquette National Bank of Minneapolis* v. *First of Omaha Service Corp.*, 439 U.S. 299 (1978)) that Section 85 preempted state laws limiting the maximum interest rates that national banks may charge their credit-card customers. *See Smiley*, 517 U.S. at 737, 744. The question in *Smiley* concerned the *extent* of that preemption.

Smiley held that the Comptroller's interpretation of the statute's preemptive scope merited *Chevron* deference. The Comptroller was "'charged with the enforcement of banking laws to an extent that warrants the invocation of the rule of deference with respect to his deliberative conclusions as to the meaning of these laws.'" 517 U.S. at 739 (brackets and citation omitted). The statute included a general grant of authority, closely similar to FEHBA's provision, to prescribe regulations implementing the federal banking laws. 12 U.S.C. § 93a (1996); *see also id.* § 1 (1996). Exercising that authority, the Comptroller issued a regulation construing the term "'interest'" in Section 85 to include "late-payment fees" that

banks charged credit-card customers. *Smiley*, 517 U.S. at 737, 740.

This Court unanimously held that the Comptroller's interpretation was "reasonable" and therefore "entitled to deference" under *Chevron*—*even though* it had the effect of determining the extent to which state laws were preempted. 517 U.S. at 745-47. The Court reserved judgment on whether *Chevron* applies to "the question of *whether* a statute is pre-emptive"—*i.e.*, whether it displaces *any* state laws—because "there [was] no doubt that § 85 pre-empts state law" to *some* extent, given this Court's prior precedent in *Marquette*. *Id.* at 744. The only dispute in *Smiley* concerned the "substantive ... *meaning* of [the] statute," *i.e.*, *which* state laws were preempted. *Ibid.* On *that* issue, *Smiley* held, *Chevron* applies with full force. *Ibid.* So long as the agency's interpretation of the statute's "meaning" is "a reasonable one," it controls, whether or not a court believes that "it represents the best interpretation." *Id.* at 744-45.

That is precisely the case here. As in *Smiley*, "there is no doubt that" FEHBA "pre-empts state law" to *some* extent. 517 U.S. at 744. Section 8902(m)(1) explicitly "supersede[s] and preempt[s]" some state laws. 5 U.S.C. § 8902(m)(1). The only dispute is *which* state laws. OPM's reasonable conclusion on that question concerns FEHBA's "substantive ... *meaning*," and so is "entitled to deference" under *Chevron*. *Smiley*, 517 U.S. at 744, 747.

The Missouri Supreme Court misread *Smiley* as "indicat[ing] that *Chevron* deference does *not* apply to provisions ... that deal expressly with preemption." Pet. App. 9a (emphasis added). Seizing on *Smiley*'s distinction between the "substantive" versus the "pre-emptive" meaning of a statute, the decision

below deemed *Chevron* categorically inapplicable to express-preemption provisions. *Ibid.* That reading turns *Smiley*'s holding upside-down. *Smiley*'s central point was that, where a statute unambiguously does preempt some laws, the extent of preemption is a question of its "substantive ... meaning," to which the *Chevron* framework *does* apply. 517 U.S. at 744. Indeed, the statute in *Smiley* was indistinguishable from an express-preemption provision; as *Smiley* came to this Court, it already was settled—by this Court's decision in *Marquette*—that the statute preempted some laws. *Ibid.* Given this Court's unanimous holding that *Chevron* applied to *that* statute, it makes no sense to withhold deference with respect to an agency's reading of a statute that on its face preempts state law.

ii. This Court's decisions since *Smiley* confirm that *Chevron* applies to an agency's reasonable interpretation of the *scope* of a statute that expressly preempts state law.

Only weeks after *Smiley*, in *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470 (1996), this Court deferred under *Chevron* to a Food and Drug Administration ("FDA") regulation addressing the scope of the express-preemption provision of the Medical Device Amendments to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 360k(a). 518 U.S. at 496-97. The FDA had construed that statute not to "'preempt [certain] State or local requirements'"—namely, those that are "'equal'" or "'identical'" to requirements imposed by the statute or the FDA. *Ibid.* (citation omitted). Invoking *Chevron*, the Court deferred to that reading. *Id.* at 496. "The ambiguity in the statute—and the congressional grant of authority to the agency on the matter contained within it—provide a 'sound basis'

for giving substantial weight to the agency's view of the statute." *Ibid.* (citations omitted). The FDA "is the federal agency to which Congress has delegated its authority to implement the provisions of the Act," and it is "uniquely qualified to determine whether a particular form of state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress'"—and "therefore, whether [state law] should be pre-empted." *Ibid.* (citation omitted). Although Coventry and the United States brought *Medtronic* to the Missouri Supreme Court's attention, that court never addressed *Medtronic*'s relevant holding applying *Chevron*.

More recently, the Court held in *Cuomo* v. *Clearing House Association, LLC*, 557 U.S. 519 (2009), that "the familiar *Chevron* framework" applied to another express-preemption provision. *Id.* at 525. Like *Smiley*, *Clearing House* involved a regulation issued by the Comptroller of the Currency concerning the preemptive scope of a provision of the National Bank Act, this one concerning the "visitorial powers" of state regulators over national banks. *Id.* at 524-25. The Court explained that the Comptroller, "charged with administering" the statute, is entitled under *Chevron* to "give authoritative meaning to the statute within the bounds of [the statute's] uncertainty." *Id.* at 525. "The question presented" was therefore "whether the Comptroller's regulation purporting to pre-empt state law enforcement can be upheld as a reasonable interpretation of the National Bank Act." *Id.* at 523-24. The Court did not defer to the Comptroller's regulation only because the agency's interpretation of the statute in its regulation contradicted the statute's "clear" meaning. *Id.* at 525. The relevant statute contained some ambiguity, but the "Comptroller's expansive regulation" had

strayed far beyond the "outer limits" of that ambiguity. *Ibid.*

Here too, however, the decision below dodged this Court's relevant holding. It wrote off *Clearing House* because this Court did not ultimately accept the agency's reading of the specific statute. Pet. App. 11a-12a. But the Missouri Supreme Court had no answer to this Court's explicit holding that "the familiar *Chevron* framework" *applied*. 557 U.S. at 525.

c. Even if the Missouri Supreme Court were correct that this Court had never "expressly held" *Chevron* applicable to interpreting preemption provisions, it offered no valid reason why, as an original matter, *Chevron* should not apply. The decision below appeared to reason that the presumption against preemption superseded *Chevron*. *See* Pet. App. 6a-10a. But that presumption has no proper application to FEHBA's preemption provision. *Supra* pp. 36-42. And even if the presumption were otherwise applicable, elevating it over ordinary principles of administrative deference further contravenes this Court's teaching, and would create an illogical anomaly in federal law.

Smiley specifically confronted and rejected the assertion that "'the presumption against ... pre-emption' ... in effect trumps *Chevron*" in construing the scope of a preemption provision. 517 U.S. at 743 (citation omitted). The petitioner in *Smiley* urged that "*no* Comptroller interpretation of § 85" of the National Bank Act "is entitled to deference, because § 85 is a provision that preempts state law," and that the presumption "requires a court to make its own interpretation of" the statute "that will avoid (to the extent possible) pre-emption of state law." *Id.* at 743-44. "This argument," the Court held, "confuses

the question of the substantive (as opposed to pre-emptive) *meaning* of a statute with the question of *whether* a statute is pre-emptive." *Id.* at 744. "[A]ssuming (without deciding) that the latter question must always be decided *de novo* by courts," *Smiley* held that an agency's position on the *former* question—the scope, *i.e.*, the "*meaning*," of a statute that undisputedly preempts some state laws—"deserves deference" under *Chevron*, irrespective of the presumption. *Ibid.*

The Missouri Supreme Court's contrary view, moreover, would perversely mean that federal agencies have *less* authority to deem state laws preempted when Congress *explicitly* displaces state law than in administering statutes that do *not* address preemption. This Court has long held that regulations issued by an agency acting within its authority "have no less preemptive effect than federal statutes." *Capital Cities Cable, Inc.* v. *Crisp*, 467 U.S. 691, 699 (1984) (quoting *Fid. Fed. Sav. & Loan Ass'n* v. *de la Cuesta*, 458 U.S. 141, 153-54 (1982)). "Where Congress has directed an administrator to exercise his discretion, his judgments"—concerning preemption no less than other subjects—"are subject to judicial review only to determine whether he has exceeded his statutory authority or acted arbitrarily." *Ibid.* (citation omitted). Thus, "in the area of pre-emption, if the agency's choice to pre-empt 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, [courts] should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned.'" *City of New York* v. *FCC*, 486 U.S. 57, 64 (1988) (citation omitted); *see also City of Arlington*, 133 S. Ct. at 1871. And evaluating

whether the agency is "'acting within the scope of its congressionally delegated authority' ... does *not* involve a 'presumption against pre-emption.'" *New York* v. *FERC*, 535 U.S. 1, 18 (2002) (emphasis added) (citation omitted). Courts simply "interpret the statute to determine whether Congress has given [the agency] the power to act as it has ... without any presumption one way or the other." *Ibid.*

If Section 8902(m)(1) did not exist, therefore, and if OPM had promulgated its regulation preempting state antisubrogation and antireimbursement laws simply as an exercise of its statutory authorization to "prescribe regulations necessary to carry out" FEHBA, 5 U.S.C. § 8913(a), there would be no question that OPM's determination is entitled to deference. Its regulation would be reviewable only to determine whether OPM "exceeded [its] statutory authority or acted arbitrarily." *Capital Cities*, 467 U.S. at 699. And no presumption against preemption would apply. *See New York*, 535 U.S. at 18. Yet on the Missouri Supreme Court's view, OPM's determination deserves *no* deference—and the presumption against preemption *does* apply—because Congress *explicitly* preempted state laws, and OPM's regulation construed the scope of that express-preemption provision. That irrational result is not and cannot be the law.

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Whether as an original matter of statutory interpretation or as a straightforward application of *Chevron*, the correct reading of FEHBA is the same: The statute preempts state laws preventing carriers from seeking subrogation and reimbursement under their FEHBA contracts.

II. FEHBA'S EXPRESS-PREEMPTION PROVISION COMPORTS WITH THE SUPREMACY CLAUSE.

The Missouri Supreme Court alternatively held that FEHBA does not preempt state laws barring subrogation and reimbursement for a second reason: The six concurring judges opined that Section 8902(m)(1) violates the Supremacy Clause, and so presumably preempts *nothing*. Pet. App. 14a. Under Missouri law, that "concurring opinion" in which "a majority of the court concurred" also constitutes a precedential holding of the court. *Mueller* v. *Burchfield*, 224 S.W.2d 87, 89 (Mo. 1949); *accord State ex rel. Bothwell* v. *Green*, 180 S.W.2d 12, 13 (Mo. 1944). That alternative, constitutional holding is unsustainable.

The Supremacy Clause provides that "the Laws of the United States which shall be made in Pursuance [of the Constitution] ... shall be the supreme Law of the Land; ... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. FEHBA's preemption provision is perfectly consistent with that constitutional imperative. Section 8902(m)(1) *itself* declares that the state and local laws it covers are "supersede[d] and preempt[ed]." 5 U.S.C. § 8902(m)(1). It is thus the *statute* Congress enacted—one of "the Laws of the United States ... made in Pursuance" of the Constitution, U.S. Const. art. VI, cl. 2—that displaces state law. That is all the Supremacy Clause requires.

Adopting the reasoning of Judge Wilson's prior concurrence in *Nevils I* (Pet. App. 66a-72a), however, the six-judge concurrence below held that Section 8902(m)(1) is invalid because it improperly "attempt[s] to give preemptive effect to the provisions of

a contract between the federal government and a private party." *Id.* at 14a. That conclusion is untenable. It is Section 8902(m)(1) itself, by its express terms, that declares state laws "supersede[d] and preempt[ed]," to make room for FEHBA contracts to operate. That Section 8902(m)(1) defines the *scope* of the laws FEHBA preempts partly by reference to OPM's contracts is immaterial. The fact remains that *Congress*, in a duly enacted statute, decided to preempt state law, and to what extent.

FEHBA's approach of defining the extent of preemption by reference to contracts, in fact, is unremarkable. Congress prescribes the scope of preemption in a variety of ways. Sometimes it supersedes all state laws on a topic. *See, e.g.*, *Morales*, 504 U.S. at 383 (applying statute that preempted "'any law, rule, regulation, standard, or other provision ... relating to rates, routes, or services of any air carrier'" (quoting 49 U.S.C. app. § 1305(a)(1) (1988))). In other contexts, Congress preempts state laws that differ from or add to requirements in specific statutes. *See, e.g.*, *Riegel* v. *Medtronic, Inc.*, 552 U.S. 312, 316 (2008) (applying 21 U.S.C. § 360k(a), which preempts any state-law requirement "which is different from, or in addition to, any requirement" under certain federal statutes if it "relates to the safety or effectiveness of" a medical device).

Congress also can and does enact statutes that expressly preempt state laws that relate to a particular type of contracts or other instruments. In the context of federal-employee benefits, such provisions are commonplace. The statute in *Hillman*, for instance, preempts state laws "'inconsistent with'" the terms of "'any contract under'" federal law governing federal life-insurance benefits. 133 S. Ct. at 1948

(quoting 5 U.S.C. § 8709(d)(1)). Other statutes preempt state laws that are inconsistent with "[t]he terms of any contract that relate to the nature, provision, or extent of coverage or benefits" for federal dental, vision, long-term-care, and military service-member benefits. 5 U.S.C. §§ 8959, 8989, 9005(a); *see also* 10 U.S.C. § 1103(a). Statutes outside the federal-employee-benefits context follow the same approach. ERISA, for example, expressly preempts "'any and all State laws insofar as they ... relate to any employee benefit plan.'" *FMC*, 498 U.S. at 57 (quoting 29 U.S.C. § 1144(a)). And the Federal Arbitration Act limits the grounds for denying enforcement of any "written provision in any ... contract" providing for arbitration—thus preempting state laws that would otherwise interfere with arbitration agreements. 9 U.S.C. § 2.

If the Missouri Supreme Court were correct that FEHBA's reference to contracts violated the Supremacy Clause, then *all* of these statutes tethering the scope of preemption to contract terms would be unconstitutional as well. In reality, all of these provisions comply with the Clause for the same reason FEHBA does: In each instance, as in Section 8902(m)(1), it is the *statute*—not the categories of contracts it identifies—that preempts state law.

Indeed, FEHBA is on even surer constitutional footing than ERISA or the Federal Arbitration Act—both of which this Court has repeatedly held preempt state laws, *see, e.g.*, *Gobeille*, 136 S. Ct. at 942-47; *Marmet Health Care Ctr., Inc.* v. *Brown*, 132 S. Ct. 1201, 1203-04 (2012) (per curiam). Unlike those statutes, which tie the scope of preemption to purely *private* contracts, FEHBA prevents state laws from frustrating contracts made with a federal agency,

pursuant to a federal statute, for the operation of a federal-government program. 5 U.S.C. § 8902(a), (m)(1). States' authority to interfere with such contracts would be sharply limited even in the absence of an express-preemption provision. *See Clearfield Tr. Co.* v. *United States*, 318 U.S. 363, 366 (1943); *cf. Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 507-09 (1988). Congress assuredly has authority to prevent state-law interference with such contracts explicitly.

The Missouri Supreme Court's constitutional concern, in short, is eliminated by sensibly construing Section 8902(m)(1) as giving preemptive effect to federal law—not contracts themselves. That is by far the best reading of FEHBA's text in context. And it is how OPM has long construed the statute. *See Proposed Rule*, 80 Fed. Reg. at 932 (Pet. App. 153a) ("OPM has consistently taken the position that *the FEHB Act preempts* state laws that restrict or prohibit FEHB Program carrier reimbursement and/or subrogation recovery efforts" (emphasis added)).

At a bare minimum, the statute *can* fairly be read in that fashion, and therefore it *must* be so interpreted to avoid any constitutional concern. "'[T]he elementary rule is that every reasonable construction must be resorted to, in order to save a statute from unconstitutionality.'" *Edward J. DeBartolo Corp.* v. *Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988) (citation omitted). Thus, "where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Ibid.*

As the Second Circuit explained in the decision affirmed in *McVeigh*, Section 8902(m)(1) can be "rea-

sonably construe[d] ... as requiring that, in cases involving the 'terms of any contract under [FEHBA] which relate to the nature, provision, or extent of coverage or benefits,' *federal law* 'shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.'" *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136, 144-45 (2d Cir. 2005) (Sotomayor, J.) (alteration in original) (citation omitted), *aff'd*, 547 U.S. 677. That interpretation obviates any possible constitutional concern, and it is "faithful ... to [Section 8902(m)(1)'s] plain language and respects Congress's stated intent to maintain 'uniformity' in FEHBA benefits and to 'displace State or local law relating to health insurance or plans.'" *Ibid.* (citation omitted). Even the dissent agreed on this point, *id.* at 156 (Raggi, J., dissenting), as have other courts to consider the issue. *See Bell*, 823 F.3d at 1204; *Kobold*, 370 P.3d at 131 n.2.

Rather than construe FEHBA sensibly to avoid any constitutional question, however, the Missouri Supreme Court skewed the statute to *create* one. The concurring judges (adopting Judge Wilson's analysis in *Nevils I*) specifically rejected a construction of FEHBA that comports with the Supremacy Clause, and insisted on interpreting Section 8902(m)(1) as "giv[ing] preemptive effect to the provisions of a contract." Pet. App. 14a, 70a-71a. That conclusion invalidates Section 8902(m)(1) *in toto*. If upheld, it would mean that FEHBA's express-preemption provision actually preempts *nothing*. The result would be open season for state-law interference with the FEHBA Program. *Every* aspect of FEHBA contracts, which provide benefits for millions of federal workers and dependents, would be at risk of regulation by a patchwork of state laws—even

those provisions, including subrogation and reimbursement terms, that federal regulations *require* FEHBA contracts to contain, 5 C.F.R. § 890.106(a); *see also Kobold*, 370 P.3d at 131 n.2.

The Missouri Supreme Court's strained statutory interpretation, which causes rather than averts a constitutional conflict, has nothing to commend it. And there is more than ample reason to reject it. This Court should hold that FEHBA itself validly preempts state law—including laws, like Missouri's, that prevent FEHBA carriers from fulfilling their contractual obligations to the federal government to seek subrogation and reimbursement recoveries.

CONCLUSION

The Missouri Supreme Court's judgment should be reversed.

Respectfully submitted.

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APPENDIX

APPENDIX

(All provisions reflect current text except where otherwise indicated.)

U.S. Const. art. VI, cl. 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

5 U.S.C. § 8709. Insurance policies

(a) The Office of Personnel Management, without regard to section 6101(b) to (d) of title 41, may purchase from one or more life insurance companies a policy or policies of group life and accidental death and dismemberment insurance to provide the benefits specified by this chapter. A company must meet the following requirements:

(1) It must be licensed to transact life and accidental death and dismemberment insurance under the laws of 48 of the States and the District of Columbia.

(2) It must have in effect, on the most recent December 31 for which information is available to the Office, an amount of employee group life insurance equal to at least 1 percent of the total amount of employee group life insurance in the United States in all life insurance companies.

(b) A company issuing a policy under subsection (a) of this section shall establish an administrative office under a name approved by the Office.

(c) The Office at any time may discontinue a policy purchased from a company under subsection (a) of this section.

(d) (1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any law of any State or political subdivision thereof, or any regulation issued thereunder, which relates to group life insurance to the extent that the law or regulation is inconsistent with the contractual provisions.

(2) For the purpose of this section, "State" means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and a territory or possession of the United States.

5 U.S.C. § 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) an employee as defined by section 2105 of this title;

(B) a Member of Congress as defined by section 2106 of this title;

(C) a Congressional employee as defined by section 2107 of this title;

(D) the President;

(E) an individual first employed by the government of the District of Columbia before October 1, 1987;

(F) an individual employed by Gallaudet College;[1]

(G) an individual employed by a county committee established under section 590h(b) of title 16;

(H) an individual appointed to a position on the office staff of a former President under section 1(b) of the Act of August 25, 1958 (72 Stat. 838);

(I) an individual appointed to a position on the office staff of a former President, or a former Vice President under section 5 of the Presidential Transition Act of 1963, as amended (78 Stat. 153), who immediately before the date of such appointment was an employee as defined under any other subparagraph of this paragraph; and

(J) an individual who is employed by the Roosevelt Campobello International Park Commission and is a citizen of the United States,

but does not include—

(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

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[1] See Change of Name note below.

(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

(iii) an employee of the Tennessee Valley Authority; or

(iv) an employee excluded by regulation of the Office of Personnel Management under section 8913(b) of this title;

(2) "Government" means the Government of the United States and the government of the District of Columbia;

(3) "annuitant" means—

(A) an employee who retires—

(i) on an immediate annuity under subchapter III of chapter 83 of this title, or another retirement system for employees of the Government, after 5 or more years of service;

(ii) under section 8412 or 8414 of this title;

(iii) for disability under subchapter III of chapter 83 of this title, chapter 84 of this title, or another retirement system for employees of the Government; or

(iv) on an immediate annuity under a retirement system established for employees described in section 2105(c), in the case of an individual who elected under section 8347(q)(2) or 8461(n)(2) to remain subject to such a system;

(B) a member of a family who receives an immediate annuity as the survivor of an employee (including a family member entitled to an amount under section 8442(b)(1)(A), whether or not such family member is entitled to an annuity under section 8442(b)(1)(B)) or of a retired employee described by subparagraph (A) of this paragraph;

(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

(D) a member of a family who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of—

(i) an employee who dies as a result of injury or illness compensable under that subchapter; or

(ii) a former employee who is separated after having completed 5 or more years of service and who dies while receiving monthly compensation under that subchapter and who has been held by the Secretary to have been unable to return to duty;

(4) "service", as used by paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 or chapter 84 of this title;

(5) "member of family" means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including—

(A) an adopted child or recognized natural child; and

(B) a stepchild or foster child but only if the child lives with the employee or annuitant in a regular parent-child relationship;

or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

(6) "health benefits plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization and an association of organizations or other

entities described in this paragraph sponsoring a health benefits plan;

(8) "employee organization" means—

(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title; and

(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title, applied to the Office for approval of a plan provided under such section;

(9) "dependent", in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe;

(10) "former spouse" means a former spouse of an employee, former employee, or annuitant—

(A) who has not remarried before age 55 after the marriage to the employee, former employee, or annuitant was dissolved,

(B) who was enrolled in an approved health benefits plan under this chapter as a family member at any time during the 18-

month period before the date of the dissolution of the marriage to the employee, former employee, or annuitant, and

(C) (i) who is receiving any portion of an annuity under section 8345(j) or 8467 of this title or a survivor annuity under section 8341(h) or 8445 of this title (or benefits similar to either of the aforementioned annuity benefits under a retirement system for Government employees other than the Civil Service Retirement System or the Federal Employees' Retirement System),

(ii) as to whom a court order or decree referred to in section 8341(h), 8345(j), 8445, or 8467 of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System or the Federal Employees' Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) or 8417(b) of this title (or similar provision of law), or (iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former employee's separation from the service (other than by retirement); and

(11) "qualified clinical social worker" means an individual—

(A) who is licensed or certified as a clinical social worker by the State in which such individual practices; or

(B) who, if such State does not provide for the licensing or certification of clinical social workers—

(i) is certified by a national professional organization offering certification of clinical social workers; or (ii) meets equivalent requirements (as prescribed by the Office).

5 U.S.C. § 8902(m)(1). Contracting authority (1982)

* * *

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

* * *

5 U.S.C. § 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k) (1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued

coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(*l*) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1)[1] of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).

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[1] See References in Text note below.

(m) (1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2) (A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(*o*) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

5 U.S.C. § 8906. Contributions

(a) (1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

(A) enrollments under this chapter for self alone;

(B) enrollments under this chapter for self plus one; and

(C) enrollments under this chapter for self and family.

(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be

commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

(3) For purposes of paragraph (2), the term "enrollee" means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

(b) (1) Except as provided in paragraphs (2), (3), and (4), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1)(A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

(2) The biweekly Government contribution for an employee or annuitant enrolled in a plan under this chapter shall not exceed 75 percent of the subscription charge.

(3) In the case of an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title), the biweekly Government contribution shall be equal to the percentage which bears the same ratio to the percentage determined under this subsection (without regard to this paragraph) as the average number of hours of such employee's regularly scheduled workweek bears to the average

number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time career basis (as determined under regulations prescribed by the Office).

(4) In the case of persons who are enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10, the Government contribution shall be subject to the limitation set forth in subsection (i) of that section.

(c) There shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) the annuity of each enrolled annuitant and there shall be contributed by the Government, amounts, in the same ratio as the contributions of the employee or annuitant and the Government under subsection (b) of this section, which are necessary for the administrative costs and the reserves provided for by section 8909(b) of this title.

(d) The amount necessary to pay the total charge for enrollment, after the Government contribution is deducted, shall be withheld from the pay of each enrolled employee and (except as provided in subsection (i) of this section) from the annuity of each enrolled annuitant. The withholding for an annuitant shall be the same as that for an employee enrolled in the same health benefits plan and level of benefits.

(e) (1) (A) An employee enrolled in a health benefits plan under this chapter who is placed in a leave without pay status may have his coverage and the coverage of members of his family continued under the plan for not to exceed 1 year under regulations prescribed by the Office.

(B) During each pay period in which an enrollment continues under subparagraph (A)—

(i) employee and Government contributions required by this section shall be paid on a current basis; and

(ii) if necessary, the head of the employing agency shall approve advance payment, recoverable in the same manner as under section 5524a(c), of a portion of basic pay sufficient to pay current employee contributions.

(C) Each agency shall establish procedures for accepting direct payments of employee contributions for the purposes of this paragraph.

(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of an organization composed primarily of employees as defined by section 8901 of this title, within 60 days after entering on that leave without pay, may file with his employing agency an election to continue his health benefits enrollment and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of leave without pay. The employing agency shall forward the enrollment charges so paid to the Fund. If the employee does not so elect, his enrollment will continue during nonpay status and end as provided by paragraph (1) of this subsection and implementing regulations.

(3) (A) An employing agency may pay both the employee and Government contributions, and any additional administrative expenses otherwise chargeable to the employee, with respect to health care coverage for an employee described in subparagraph (B) and the family of such employee.

(B) An employee referred to in subparagraph (A) is an employee who—

(i) is enrolled in a health benefits plan under this chapter;

(ii) is a member of a reserve component of the armed forces;

(iii) is called or ordered to active duty in support of a contingency operation (as defined in section 101(a)(13) of title 10);

(iv) is placed on leave without pay or separated from service to perform active duty; and

(v) serves on active duty for a period of more than 30 consecutive days.

(C) Notwithstanding the one-year limitation on coverage described in paragraph (1)(A), payment may be made under this paragraph for a period not to exceed 24 months.

(f) The Government contribution, and any additional payments under subsection (e)(3)(A), for health benefits for an employee shall be paid—

(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

(3) in the case of an employee of the legislative branch who is paid by the Chief Administrative Officer of the House of Representatives, from the applicable accounts of the House of Representatives; and

(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

(g) (1) Except as provided in paragraphs (2) and (3), the Government contributions authorized by this section for health benefits for an annuitant shall be paid from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

(2) (A) The Government contributions authorized by this section for health benefits for an individual who first becomes an annuitant by reason of retirement from employment with the United States Postal Service on or after July 1, 1971, or for a survivor of such an individual or of an individual who died on or after July 1, 1971, while employed by the United States Postal Service, shall through September 30, 2016, be paid by the United States Postal Service, and thereafter shall be paid first from the Postal Service Retiree Health Benefits Fund up to the amount contained in the Fund, with any remaining amount paid by the United States Postal Service.

(B) In determining any amount for which the Postal Service is liable under this paragraph, the amount of the liability shall be prorated to reflect only that portion of total service which is attributable to civilian service performed (by the former postal employee or by the deceased individual referred to in subparagraph (A), as the case may be) after June 30, 1971, as estimated by the Office of Personnel Management.

(3) The Government contribution for persons enrolled in a health benefits plan as part of the demonstration project under section 1108 of title 10 shall be paid as provided in subsection (i) of that section.

(h) The Office shall provide for conversion of biweekly rates of contribution specified by this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

(i) An annuitant whose annuity is insufficient to cover the withholdings required for enrollment in a particular health benefits plan may enroll (or remain enrolled) in such plan, notwithstanding any other provision of this section, if the annuitant elects, under conditions prescribed by regulations of the Office, to pay currently into the Employees Health Benefits Fund, through the retirement system that administers the annuitant's health benefits enrollment, an amount equal to the withholdings that would otherwise be required under this section.

5 U.S.C. § 8907. Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by sections 8903 and 8903a of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the—

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

5 U.S.C. § 8909. Employees Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available—

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other re-

funds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter. If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such

organization (as determined under section 8903a(d) of this title).

(e) (1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

(f) (1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan admin-

istration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(g) The fund described in subsection (a) is available to pay costs that the Office incurs for activities associated with implementation of the demonstration project under section 1108 of title 10.

5 U.S.C. § 8913(a). Regulations (1970)

(a) The Civil Service Commission may prescribe regulations necessary to carry out this chapter.

* * *

5 U.S.C. § 8913. Regulations

(a) The Office of Personnel Management may prescribe regulations necessary to carry out this chapter.

(b) The regulations of the Office may prescribe the time at which and the manner and conditions under which an employee is eligible to enroll in an approved health benefits plan described by section 8903 or 8903a of this title. The regulations may exclude an employee on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointment, seasonal or intermittent employment, and employment of like nature. The Office may not exclude—

(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years;

(3) an employee who is occupying a position on a part-time career employment basis (as defined in section 3401(2) of this title); or

(4) an employee who is employed on a temporary basis and is eligible under section 8906a(a).

(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans. The regulations may permit the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(g) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the month in which an annuitant or former spouse ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of members of his family for not to exceed 90 days.

(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.

5 U.S.C. § 8959. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to dental benefits, insurance, plans, or contracts.

5 U.S.C. § 8989. Preemption

The terms of any contract that relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to vision benefits, insurance, plans, or contracts.

5 U.S.C. § 9005. Preemption

(a) CONTRACTUAL PROVISIONS.—The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to long-term care insurance or contracts.

(b) PREMIUMS.—

(1) IN GENERAL.—No tax, fee, or other monetary payment may be imposed or collected, directly or indirectly, by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, on, or with respect to,

any premium paid for an insurance policy under this chapter.

(2) RULE OF CONSTRUCTION.—Paragraph (1) shall not be construed to exempt any company or other entity issuing a policy of insurance under this chapter from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such entity from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

9 U.S.C. § 2. Validity, irrevocability, and enforcement of agreements to arbitrate

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

10 U.S.C. § 1103. Contracts for medical and dental care: State and local preemption

(a) OCCURRENCE OF PREEMPTION.—A law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods shall not apply to any contract entered into pursuant to this chapter by the

Secretary of Defense or the administering Secretaries to the extent that the Secretary of Defense or the administering Secretaries determine that—

(1) the State or local law or regulation is inconsistent with a specific provision of the contract or a regulation promulgated by the Secretary of Defense or the administering Secretaries pursuant to this chapter; or

(2) the preemption of the State or local law or regulation is necessary to implement or administer the provisions of the contract or to achieve any other important Federal interest.

(b) EFFECT OF PREEMPTION.—In the case of the preemption under subsection (a) of a State or local law or regulation regarding financial solvency, the Secretary of Defense or the administering Secretaries shall require an independent audit of the prime contractor of each contract that is entered into pursuant to this chapter and covered by the preemption. The audit shall be performed by the Defense Contract Audit Agency.

(c) STATE DEFINED.—In this section, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, and each possession of the United States.

12 U.S.C. § 1. Office of Comptroller of the Currency (1996)

There shall be in the Department of the Treasury a bureau charged with the execution of all laws passed by Congress relating to the issue and regulation of a national currency secured by United States bonds

and, under the general supervision of the Board of Governors of the Federal Reserve System, of all Federal Reserve notes, except for the cancellation and destruction, and accounting with respect to such cancellation and destruction, of Federal Reserve notes unfit for circulation, the chief officer of which bureau shall be called the Comptroller of the Currency, and shall perform his duties under the general directions of the Secretary of the Treasury. The Comptroller of the Currency shall have the same authority over matters within the jurisdiction of the Comptroller as the Director of the Office of Thrift Supervision has over matters within the Director's jurisdiction under section 1462a(b)(3) of this title. The Secretary of the Treasury may not delay or prevent the issuance of any rule or the promulgation of any regulation by the Comptroller of the Currency.

12 U.S.C. § 85. Rate of interest on loans, discounts and purchases

Any association may take, receive, reserve, and charge on any loan or discount made, or upon any notes, bills of exchange, or other evidences of debt, interest at the rate allowed by the laws of the State, Territory, or District where the bank is located, or at a rate of 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and no more, except that where by the laws of any State a different rate is limited for banks organized under State laws, the rate so limited shall be allowed for associations organized or existing in any such State under title 62 of the Revised Statutes. When no rate is

fixed by the laws of the State, or Territory, or District, the bank may take, receive, reserve, or charge a rate not exceeding 7 per centum, or 1 per centum in excess of the discount rate on ninety day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and such interest may be taken in advance, reckoning the days for which the note, bill, or other evidence of debt has to run. The maximum amount of interest or discount to be charged at a branch of an association located outside of the States of the United States and the District of Columbia shall be at the rate allowed by the laws of the country, territory, dependency, province, dominion, insular possession, or other political subdivision where the branch is located. And the purchase, discount, or sale of a bona fide bill of exchange, payable at another place than the place of such purchase, discount, or sale, at not more than the current rate of exchange for sight drafts in addition to the interest, shall not be considered as taking or receiving a greater rate of interest.

12 U.S.C. § 93a. Authority to prescribe rules and regulations (1996)

Except to the extent that authority to issue such rules and regulations has been expressly and exclusively granted to another regulatory agency, the Comptroller of the Currency is authorized to prescribe rules and regulations to carry out the responsibilities of the office, except that the authority conferred by this section does not apply to section 36 of this title or to securities activities of National Banks under the Act commonly known as the "Glass-Steagall Act".

21 U.S.C. § 360k. State and local requirements respecting devices

(a) General rule

Except as provided in subsection (b) of this section, no State or political subdivision of a State may establish or continue in effect with respect to a device intended for human use any requirement—

(1) which is different from, or in addition to, any requirement applicable under this chapter to the device, and

(2) which relates to the safety or effectiveness of the device or to any other matter included in a requirement applicable to the device under this chapter.

(b) Exempt requirements

Upon application of a State or a political subdivision thereof, the Secretary may, by regulation promulgated after notice and opportunity for an oral hearing, exempt from subsection (a) of this section, under such conditions as may be prescribed in such regulation, a requirement of such State or political subdivision applicable to a device intended for human use if—

(1) the requirement is more stringent than a requirement under this chapter which would be applicable to the device if an exemption were not in effect under this subsection; or

(2) the requirement—

(A) is required by compelling local conditions, and

(B) compliance with the requirement would not cause the device to be in violation of

any applicable requirement under this chapter.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for pur-

poses of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State

of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6) (A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements

which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3) (A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

49 U.S.C. § 41713. Preemption of authority over prices, routes, and service

(a) DEFINITION.—In this section, "State" means a State, the District of Columbia, and a territory or possession of the United States.

(b) PREEMPTION.—(1) Except as provided in this subsection, a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.

(2) Paragraphs (1) and (4) of this subsection do not apply to air transportation provided entirely in Alaska unless the transportation is air transportation (except charter air transportation) provided under a certificate issued under section 41102 of this title.

(3) This subsection does not limit a State, political subdivision of a State, or political authority of at least 2 States that owns or operates an airport served by an air carrier holding a certificate issued by the Secretary of Transportation from carrying out its proprietary powers and rights.

(4) TRANSPORTATION BY AIR CARRIER OR CARRIER AFFILIATED WITH A DIRECT AIR CARRIER.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a State, political subdivision of a State, or political authority of 2 or more States may not enact or enforce a law,

regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier or carrier affiliated with a direct air carrier through common controlling ownership when such carrier is transporting property by aircraft or by motor vehicle (whether or not such property has had or will have a prior or subsequent air movement).

(B) MATTERS NOT COVERED.—Subparagraph (A)—

(i) shall not restrict the safety regulatory authority of a State with respect to motor vehicles, the authority of a State to impose highway route controls or limitations based on the size or weight of the motor vehicle or the hazardous nature of the cargo, or the authority of a State to regulate motor carriers with regard to minimum amounts of financial responsibility relating to insurance requirements and self-insurance authorization; and

(ii) does not apply to the transportation of household goods, as defined in section 13102 of this title.

(C) APPLICABILITY OF PARAGRAPH (1).—This paragraph shall not limit the applicability of paragraph (1).

49 U.S.C. app. § 1305. Federal preemption (1988)

(a) Preemption

(1) Except as provided in paragraph (2) of this subsection, no State or political subdivision thereof and no interstate agency or other political agency of two or more States shall enact or enforce any law, rule, regulation, standard, or other provision having the force and effect of law relating to rates, routes, or services of any air carrier having authority under subchapter IV of this chapter to provide air transportation.

(2) Except with respect to air transportation (other than charter air transportation) provided pursuant to a certificate issued by the Board under section 1371 of this Appendix, the provisions of paragraph (1) of this subsection shall not apply to any transportation by air of persons, property, or mail conducted wholly within the State of Alaska.

(b) Proprietary powers and rights

(1) Nothing in subsection (a) of this section shall be construed to limit the authority of any State or political subdivision thereof or any interstate agency or other political agency of two or more States as the owner or operator of an airport served by any air carrier certificated by the Board to exercise its proprietary powers and rights.

(2) Any aircraft operated between points in the same State (other than the State of Hawaii) which in the course of such operation crosses a boundary between two States, or between the United States and any other country, or between a State and the beginning of the territorial waters of the United States,

shall not, by reason of crossing such boundary, be considered to be operating in interstate or overseas air transportation.

(c) Existing State authority

When any intrastate air carrier which on August 1, 1977, was operating primarily in intrastate air transportation regulated by a State receives the authority to provide interstate air transportation, any authority received from such State shall be considered to be part of its authority to provide air transportation received from the Board under subchapter IV of this chapter, until modified, suspended, amended, or terminated as provided under such subchapter.

(d) "State" defined

For purposes of this section, the term "State" means any State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, Guam, the Virgin Islands, and any territory or possession of the United States.

5 C.F.R. § 890.101. Definitions; time computations *(excerpts)*

* * *

Reimbursement means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection withthat illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the

covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

* * *

Subrogation means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

* * *

5 C.F.R. § 890.106. Carrier entitlement to pursue subrogation and reimbursement recoveries

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b) (1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall

provide that benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 C.F.R. § 890.503. Reserves

(a) The enrollment charge consists of the rate approved by OPM for payment to the plan for each enrollee, plus 4 percent, of which one part is for an administrative reserve and 3 parts are for a contingency reserve for the plan.

(b) The administrative reserve is credited with the one one-hundred-and-fourth of the enrollment charge set aside for the administrative reserve. The administrative reserve is available for payment of administrative expenses of OPM incurred under this part, and for such other purposes as may be authorized by law.

(c) (1) *Contingency reserve.* The contingency reserve for each plan is credited with—

(i) The three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from the enrollment charges for employees and annuitants enrolled for that plan;

(ii) Amounts transferred in accordance with law from other contingency reserves and the administrative reserve;

(iii) Income from investment of the reserve;

(iv) Its proportionate share of the income from investment of the administrative reserve; and

(v) Any return of reserves of the plan.

(2) *Contingency reserve minimum balance.* The preferred minimum balance for the contingency reserve for community-rated plans is 1 month's subscription charges at the average recurring monthly rate paid from the Employees Health Benefits Fund for the plan during the most recent contract period. The preferred minimum balance for the contingency reserve for experience-rated plans is 1½ times an amount equal to the sum of an average month's paid claims plus an

average month's administrative expenses and retentions, as determined under paragraph (c)(3) of this section. Amounts in excess of the preferred minimum balance for a contingency reserve account may be used with respect to the plan from which the reserve derives: To defray increases in future rates; to increase plan benefits, or to reduce contributions of eligible subscribers and the Government under the program through devices such as temporary suspension of, or reduction in, required contributions or a refund of contributions to eligible subscribers and the Government.

(3) *OPM/carrier reserve transfers.* The target level for total reserves of an experience-rated plan is 31/2 times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions. Reserves include funds set aside for incurred-but-unpaid benefit claims and the "special" reserve representing the cumulative difference between income to the plan (subscription income plus interest on investments) and plan expenses (benefit costs plus administrative expenses and retentions). Included as carrier reserves is the balance in the letter of credit (LOC) account maintained by OPM for the plan. For the purposes of this section, an average month's paid claims is one-sixth of the total claims paid during the last 6 months of the most recent contract period, and an average month's administrative expenses and retentions is one-twelfth of the administrative expenses and retentions for the most recent contract period.

(i) When, as of the end of a contract period, the total of all the reserves for an experience-

rated plan is less than the target level described in the first four sentences of paragraph (c)(3) of this section, the carrier is entitled to payment from the contingency reserve. Such contingency reserve payment shall equal the lesser of: An amount equal to the difference between the target level for the plan's reserves and the total of the reserves for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. OMP must authorize this payment promptly after accepting the accounting statement for the contract period. The contingency reserve payment so authorized will be made available to the carrier's LOC account.

(ii) When, as of the end of a contract period, the total of all reserves of an experience-rated plan amounts to more than the plan's target level, the excess over the plan's target level must be credited to the contingency reserve maintained by OPM for the plan. OPM will withdraw the excess amount from the plan's LOC account, based on reporting in the annual accounting statement for the year, no sooner than May 1, of the following year. If the accounting statement is not filed by the time limit specified in the plan's contract with OPM, OPM will estimate the amount of the excess reserves and may withdraw that amount from the plan's LOC account, or begin the process of offsetting that amount from subscription payments, no sooner than May 1. The amount withdrawn from the plan's LOC account, or offset from subscription payments,

will be credited to that plan's contingency reserve.

(4) OPM may, by agreement with the carrier, approve community rating for a comprehensive plan. If the contingency reserve of the carrier of a community-rated plan exceeds the preferred minimum balance, as described in paragraph (c)(2) of this section, the carrier may request OPM to pay to the plan a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. OPM will decide whether to allow the request in whole or in part and will advise the plan of its decision.

(5) *Special contingency reserve transfers.* In addition to those amounts, if any, paid under paragraphs (c)(2) through (c)(4) of this section, OPM may authorize such other payments from the contingency reserve as in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program. A carrier for a plan may apply to OPM at any time for a payment from the contingency reserve when the carrier has good cause, such as unexpected claims experience and variations from expected community rates. In the administration of this part, OPM will accord a high priority to deciding whether to allow requests under this paragraph in whole or in part and will promptly advise the carrier of its decision. Amounts paid from the contingency reserve under paragraphs (c)(2) through (5) of this section shall be reported as subscription income in the year in which paid. By agreement with the carrier and where good cause exists, OPM may accept payment from carrier reserves for credit to the

contingency reserve in an amount and under conditions other than those specified in paragraph (c) of this section. For carriers funded by LOC, the returned amount will be withdrawn from the plan's LOC account.

(6) *Subsidization penalty reserve.* This reserve account shall be credited with all subsidization penalties levied against community rated plans outlined in 48 CFR 1615.402(c)(3)(ii)(B). The funds in this account shall be annually distributed to the contingency reserves of all community rated plans subject to the FEHB-specific medical loss ratio threshold on a pro-rata basis. The funds will not be used for one specific carrier or plan.

48 C.F.R. § 1602.170-2. Community rate

(a) *Community rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to "a combination of cost and price analysis" relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) *Adjusted community rate* means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group, except as described in § 1615.402(c)(4).

48 C.F.R. § 1602.170-7. Experience-rate

Experience-rate means a rate for a given group that is the result of that group's actual paid claims, administrative expenses (including capitated administrative expenses), retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and economic trends. Actual paid claims include any actual or negotiated benefits payments made to providers of services for the provision of healthcare such as capitation not adjusted for specific groups, including mental health benefits capitation rates, per diems, and DRG payments.

48 C.F.R. § 1632.170. Recurring premium payments to carriers

(a) (1) *Recurring payments to carriers of community-rated plans.* OPM will pay to carriers of community-rated plans the premium payments received for the plan less the amounts credited to the contingency and administrative reserves, amounts assessed under paragraph (a)(2) of this section, and amounts due for other contractual obligations. Premium payments will be due and payable not later than 30 days after receipt by the Federal Employees Health Benefits (FEHB) Fund.

(2) The difference between one percent and the performance based percentage of the contract price described at 1615.404–4 will be multiplied by the carrier's subscription income for the year of performance and the resulting amount (performance adjustment) will be withheld from the net-to-carrier premium disbursement during the first

quarter of the following contract period unless an alternative payment arrangement is made with the carrier's Contracting Officer. Amounts withheld from a community rated plan's premium disbursement will be deposited into the plan's Contingency Reserve.

(3) Any subsidization penalty levied against a community rated plan as outlined in 48 CFR 1615.402(c)(3)(ii)(B) must be paid within 60 days from notification. If payment is not received within the 60 day period, OPM will withhold from the community rated carriers the periodic premium payment payable until fully recovered. OPM will deposit the withheld funds in the subsidization penalty reserve described in 5 CFR 890.503(c)(6).

(b) (1) *Recurring payments to carriers of experience-rated plans.* OPM will make payments on a letter of credit (LOC) basis. Premium payments received for the plan, less the amounts credited to the contingency and administrative reserves and amounts for other obligations due under the contract, will be made available for carrier drawdown not later than 30 days after receipt by the FEHB Fund.

(2) Withdrawals from the LOC account will be made on a checks-presented basis. Under a checks-presented basis, drawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.

(3) OPM may grant a waiver of the restriction of LOC disbursements to a checks-presented basis if the carrier requests the waiver in writing and

demonstrates to OPM's satisfaction that the checks-presented basis of LOC disbursements will result in significantly increased liability under the contract, or that the checks-presented basis of LOC disbursements is otherwise clearly and significantly detrimental to the operation of the plan. Payments to carriers that have been granted a waiver may be made by an alternative payment methodology, subject to OPM approval.